DOCUMENT RESUME

ED 424 532 CG 028 842

TITLE	Preventing Substance Abuse among Children and Adolescents: Family-Centered Approaches. Practitioner's Guide. Prevention Enhancement Protocols System (PEPS) Series.
INSTITUTION	Birch & Davis Associates, Inc., Silver Spring, MD.
SPONS AGENCY	Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Substance Abuse Prevention.
REPORT NO	DHHS-SMA-3224-FY98
PUB DATE	1998-00-00
NOTE	86p.; For other volumes in the "Prevention Enhancement Protocols System" series, see CG 028 814-815 and CG 028 841-843. 028 841-843.
CONTRACT	277-92-1011
AVAILABLE FROM	National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; Tel: 800-729-6686 (Toll-Free); Tel: 301-468-2600; TDD: 800-487-4889; Web Site: http://www.health.org
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Adolescents; Children; Family Needs; Family Problems; *Family Programs; Mental Health; *Parent Child Relationship; Parenting Skills; *Prevention; Program Development; Resilience (Personality); Social Support Groups; *Substance Abuse; *Therapy
IDENTIFIERS	Prevention Enhancement Protocols System

ABSTRACT

This guideline summarizes state-of-the-art approaches and interventions designed to strengthen the role of families in substance abuse prevention. Topics discussed are: (1) "Why Use Family-Centered Approaches? Aren't Our School and Community Efforts Sufficient?"; (2) "How Big a Problem Is Substance Abuse Among Youth?"; (3) "What Puts Children and Adolescents at Risk for Substance Abuse?"; (4) "Family-Centered Approaches to Prevention of Substance Abuse - What Works," which presents three major approaches; (5) "General Recommendations on Family-Centered Approaches"; and (6) "Program Development and Delivery of Family-Centered Approaches," which covers program development and planning issues. "An Afterword: Emerging Areas of Research and Practice" includes discussion of the constructs "Resilience" and "Family Support." Appendixes are: "Criteria for Establishing Levels of Evidence of Effectiveness," "Abbreviations and Glossary of Terms Used in Family-Centered Approaches to Substance Abuse Prevention," and "Resource Guide." Ideas and data in this guide were organized by means of the Prevention Enhancement Protocols System (PEPS), a systematic process for evaluating evidence from prevention research and practice, then developing recommendations for practice. (EMK)

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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Preventing Substance Abuse Among Children And Adolescents: Family-Centered Approaches

Practitioner's Guide

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Prevention Enhancement Protocols System (PEPS)

Prevention Enhancement Protocols System (PEPS)

PREVENTING SUBSTANCE ABUSE AMONG CHILDREN AND ADOLESCENTS: FAMILY-CENTERED APPROACHES

Practitioner's Guide

Second in a Series

Prakash L. Grover, Ph.D., Executive Editor

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
Division of State and Community Systems Development

The Prevention Enhancement Protocols System (PEPS) Series was initiated by the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA) to systematically evaluate both research and practice evidence on substance abuse prevention and make recommendations for the field. In doing so, PEPS strives to maximize the prevention efforts of State substance abuse prevention agencies, practitioners, and local communities.

Prakash L. Grover, Ph.D., M.P.H., is the program director of PEPS and the Executive Editor of the Guideline series for the Center for Substance Abuse Prevention (CSAP). Mary Davis, Dr.P.H., succeeded by Robert Bozzo, served as team leader for the PEPS staff during the development process for this series of publications. With assistance from the Expert Panel, the PEPS staff, primarily Mim Landry, Susan Weber, and Deborah Shuman, wrote and edited the main guideline through several iterations. Karol Kumpfer, Ph.D., panel chair, was also a major contributor. Donna Dean wrote the Practitioner's Guide and the Community Guide based on the evidence summarized in the main guideline.

Exhaustive review of the documents was conducted by Robert W. Denniston, Mark Weber, and Tom Vischi. Clarese Holden served as the Government project officer of the Prevention Technical Assistance to States (PTATS) project under which this publication was produced.

The presentations herein are those of the Expert Panel and do not necessarily reflect the opinions, official policy, or position of CSAP, SAMHSA, or the U.S. Department of Health and Human Services.

This publication was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAP by Birch & Davis Associates, Inc. (Contract No. 277-92-1011).

DHHS Publication No. (SMA) 3224-FY98.

PANEL OF EXPERTS LEADING THE DEVELOPMENT OF THE GUIDELINE PREVENTING SUBSTANCE ABUSE AMONG CHILDREN AND ADOLESCENTS:

FAMILY-CENTERED APPROACHES

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Foreword

The Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA) is committed to enhancing prevention activities as planned and implemented by federally funded State agencies and community-based organizations across the country. Through a participatory process involving policymakers, researchers, program managers, and practitioners, the Prevention Enhancement Protocols System (PEPS) is generating products that can substantially improve planning and management of prevention programs, consolidate and focus prevention interventions, and potentially serve as the foundation for prevention studies.

CSAP selected the topic of family-centered prevention approaches because problems of substance abuse among adolescents are pervasive, serious, and usually embedded in multiple issues of adolescent antisocial behavior relating to mental health, delinquency, violence, poverty, and parental and family incapacities. Additionally, etiological and intervention research is increasingly demonstrating how adolescent problems of antisocial behavior have roots in the family's structure and the greater community in which the family exists. On both the national and local levels, government, communities, and organizations are interested in finding ways to support families more effectively in their efforts to meet the needs of their children.

This guideline is designed for broad use. Its intended audiences include not only State substance abuse agencies but also national, State, and local organizations that address issues relating to children and families, such as substance abuse, delinquency, child health and welfare, and family support. It is a practical, detailed guide for considering the advantages and disadvantages of specific interventions and for planning prevention initiatives in the community.

The most important aspect of PEPS is the use of systematic protocols to prepare guidelines such as this one. Ultimately, the overarching methodological accomplishments of PEPS may have far greater influence than any single guideline, for they will have given birth to a tradition of development and dissemination of science-based recommendations for the substance abuse prevention field.

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Acknowledgments

An extensive review of the evidentiary research and practice literature on a subject such as the one represented by this guideline is a collaborative venture requiring dedicated participation and the skills of many people. One can only attempt to adequately thank these individuals in a forum such as this.

On behalf of CSAP, I would like to express our deep gratitude to Dr. Karol Kumpfer and Dr. José Szapocznik, co-chairs, and members of the Expert Panel for their hard work and dedication in systematizing and synthesizing the evidence on the role of family in substance abuse prevention. The panel's vision in adding sections on emerging strategies and collateral research will be particularly useful to both practitioners and researchers. Of course, throughout this process, the leadership and guidance of the PEPS Planning Group has been invaluable. Both the Planning Group and the Expert Panel reviewed several drafts of the guideline, and their efforts are reflected in the final version. We would also like to acknowledge the contributions of the Federal Resource Panel in sharpening the focus of the guideline and for its assistance in accessing fugitive literature.

Many researchers and practitioners in the field reviewed the guideline and provided valuable comments. We believe that their incorporation has substantially improved the final product. Thanks are also due to staff in various CSAP divisions who reviewed successive versions. Special thanks are due to Tom Vischi, Mark Weber, and Bob Denniston for their extensive review and comments. I would be seriously remiss if I did not acknowledge the ongoing support of Dr. Ruth Sanchez-Way, director, Division of State and Community Prevention Systems.

Last but not least, I want to express my deep appreciation to the staff at Birch & Davis Associates, Inc., who drafted the guideline documents and tirelessly reworked them as they passed through various stages of review. The contribution of EEI Communications in final copyediting, production, and quality control is also sincerely appreciated.

Executive Editor

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About This Guideline

The Prevention Enhancement Protocols System (PEPS) is a systematic and analytical process that synthesizes a body of knowledge on specific prevention topics. It was created by the Division of State and Community Systems Development of CSAP/SAMHSA primarily to support and strengthen the efforts of State and territorial agencies responsible for substance abuse prevention activities. The PEPS program is CSAP's response to the field's need to know "what works" and is an acceptance of the responsibility to lead the field with current information supported by the best scientific knowledge available.

This second guideline in the PEPS series summarizes state-of-the-art approaches and interventions designed to strengthen the role of families in substance abuse prevention. This topic was chosen in response to the field's expressed need for direction and in recognition of the important role of the family as the first line of defense against the dangerous, insidious, and addictive consequences of substance abuse.

THE PEPS DEVELOPMENT PROCESS

The development of a PEPS guideline begins with the deliberations of a Planning Group composed of nationally known researchers and practitioners in the field of substance abuse prevention. With input from their colleagues in the field, these experts identify a topic area that meets pre-established criteria for developing a guideline. A Federal Resource Panel (FRP) with representatives from appropriate Federal agencies then convenes to discuss the proposed content of the guideline. The FRP, taking into consideration recommendations from CSAP and the PEPS Planning Group, identifies those experts in the field best suited to serve on an Expert Panel for the chosen topic.

Once formulated, the Expert Panel meets to determine the scope of the problem to be addressed in the guideline. The PEPS staff conducts exhaustive searches for relevant research and practice information, guided by the knowledge of the Expert Panel and its Chair. The studies and practice cases found are extensively analyzed and their findings compiled and presented in draft form according to the similarity of the prevention approaches used.

A subpanel of selected Expert Panel members then meets to apply the PEPS Rules of Evidence (described later in this section) to formulate summary judgments on the quality of the research and practice evidence, by approach, and to develop recommendations for the prevention field. This draft is reviewed by the full Panel. A revised version of the guideline, including the revisions of the Expert Panel, is distributed for an extensive review by the field. The critique and analysis received are used to further refine and increase the accuracy, readability, and presentation of the guideline.

PEPS SERIES GOALS

The primary goal of PEPS is to develop a systematic and consistent process for improvement of substance abuse prevention practice and research. Its objectives are to

- Synthesize research and practice evidence on selected topics
- Present recommendations for effective substance abuse prevention strategies in versions suitable for several target audiences
- Ensure that PEPS products receive optimal dissemination among target audiences
- Monitor the usefulness and relevance of PEPS products
- Identify areas in which additional research is needed

Although lessons from available science are distilled and specific recommendations are made, this guideline is not a "how-to" handbook, nor is it a prescriptive prevention planning guide. Audiences for PEPS products include State prevention agencies, other Federal and State authorities, and community-based organizations addressing the problems of substance abuse or serving high-risk populations. Therefore, targeted users of the PEPS guidelines include policy analysts and decisionmakers, who need sound data to justify funding for prevention planning; State agency and community-based administrators and managers, who will find the series useful in allocating resources and planning programs; researchers, who will receive guidance on the need for future studies; and practitioners, who will find recommendations for programming options that are most appropriate for the populations they serve.

THE SCOPE OF THIS GUIDELINE

Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches focuses on research and practice evidence for a select number of approaches to the prevention of family-related problems. The criteria used for inclusion of studies in this guideline excluded some research and practice evidence. Although other

conceptual or practice approaches do exist, sufficient documentation of their use is not yet available. The guideline describes the following three prevention approaches:

1. Parent and Family Skills Training
2. Family In-Home Support
3. Family Therapy

This practitioner's guide summarizes much of the information in the guideline and highlights practical information that is most useful to those directly involved in planning and implementing prevention programs. A brochure-length parent and community guide was also developed to provide a brief overview of substance abuse problems and courses of action for concerned citizens, and to offer tips for becoming involved in family-centered prevention.

LEVELS OF EVIDENCE

At the heart of the guideline development process are several concepts concerning the weight of the evidence that makes research or practice information strong enough to serve as the basis for recommendations. As these concepts are basic to an understanding of the rigorous process used in developing this guideline, they are explained in detail in this introductory section.

The term *research evidence* refers to the research-based body of knowledge existing for a specific prevention approach. This information is gained from scientific investigations that range in design rigor from experimental to quasi-experimental to nonexperimental. The term *practice evidence* describes information gained from prevention practice cases, which is generally presented in the form of well-designed and executed case studies that include process evaluation information on program implementation and procedures.

Each of the prevention approaches described in this guide includes at least one shaded box that presents information on *levels of evidence.* These boxes highlight the consensus of the Expert Panel on conclusions that can reasonably be drawn from an analysis of the research and/or practice evidence for each approach. They also indicate the strength of the level of cumulative evidence supporting the conclusions. The criteria for assigning levels of evidence are shown in the following boxes. The first three categories for level of evidence indicate the extent of research and practice evidence for rating the varying degrees of confirmation of positive effect. The fourth

Strong Level of Evidence

a. Consistent positive results of strong or medium effect from a series of studies, including:
   - At least three well-executed studies of experimental or quasi-experimental design

   OR

   - Two well-executed studies of experimental or quasi-experimental design

   AND

   - Consistent results from at least three case studies

b. The use of at least two different methodologies
c. Unambiguous time ordering of intervention and results
d. A plausible conceptual model ruling out or controlling for alternative causal paths or explanations

Application. This level of evidence means that practitioners can use a prevention approach with the most assurance that the approach can produce the particular effect specified in the evidence statement.

Medium Level of Evidence

a. Consistent positive results from a series of studies, including:
   - At least two well-executed studies with experimental or quasi-experimental designs

   OR

   - At least one well-executed study and three prevention case studies showing statistically significant or qualitatively clear effects

b. The use of at least two different methodologies
c. Unambiguous time ordering of intervention and results when so measured
d. A plausible conceptual model, whether or not competing explanations have been ruled out

Application. This level of evidence means that although the number or rigor of the studies reviewed is limited at this time, there is still substantial support for a prevention approach's ability to produce the particular effect specified in the evidence statement. Practitioners can proceed, but should exercise discretion in application and in assessment of process and outcomes.

Suggestive but Insufficient Evidence

This category is used to describe research and/or practice evidence that (1) is based on a plausible conceptual model or on previous research and (2) is being demonstrated in rigorous evaluation studies or appropriate intervention programs currently in process. One of two conditions typically causes evidence to be described as suggestive but insufficient:

a. In the first condition, the evidence, although limited, appears to support a conclusion, but *additional research is needed* to fully support the conclusion. This condition often applies to areas in which there has been little study, such as those that are not easily researched or new areas of study.
b. A second condition involves *equivocal results.* In this condition, a specific conclusion is supported in some studies but is not supported in others.

Application. This level of evidence means that the prevention approach has shown promise for the particular effect specified, but should be regarded as not well documented. Practitioners should be cautious about undertaking approaches with this level of evidence. However, depending on local circumstances, should the approach fit the situation and merit adoption, special attention should be given to its systematic testing and documentation.

Substantial Evidence of Ineffectiveness

This category describes research and practice evidence demonstrating that a prevention approach is not effective. The criterion for inclusion in this category is the *absence of a statistically significant effect or the observation of a statistically significant negative effect* in a majority of well-executed studies, including at least two quantitative studies with sample sizes sufficient to test for the significance of the effect.

Application. This level of evidence means that the approach has not demonstrated the intended results or has shown negative findings for the particular effect specified. Practitioners should avoid these approaches because they offer no promise of success at this time.

category applies to research and practice evidence indicating that a prevention approach is ineffective.

Using Levels of Evidence in Program Planning

Because prevention activities vary in their emphasis, scope, and content, no two research studies or practice cases are the same. As they differ in the subjects of evaluation and in the methods used, it is difficult to reach a single conclusion about a particular approach. Additionally, there may be varying levels of evidence for different desired results of a prevention approach, as shown by similar findings from more than one study. Therefore, more than one evidence statement may be made to identify and rate conclusions that can be drawn from evidence available on a single ap-

proach. For instance, studies may show that a prevention approach has *strong evidence* for attaining a desired effect in the short term, but *suggestive but insufficient evidence* for sustaining that effect over time.

The prevention approaches presented in this guide should be considered in light of local circumstances; it may not be feasible to implement only those approaches with a strong level of evidence. Local needs, interests, resources, and abilities—as well as the level of evidence—must all be considered when planners and practitioners make program development choices.

RECOMMENDATIONS FOR PRACTICE

Following the evidence-based analysis of each approach is a special section outlining recommendations for practice. This section presents the PEPS Expert Panel members' recommendations, suggestions, observations, and interpretations regarding the prevention approach evaluated in the preceding text. General recommendations and suggestions that are applicable to more than one prevention approach appear later in the chapter.

Types of Recommendations

The recommendations for practice vary considerably in nature and intent. Some are practical suggestions for optimal implementation of a particular intervention, while others suggest techniques and cautions to avoid problems. A few are practical observations about what to expect during certain prevention activities. Others interpret research findings or illustrate the practical context of prevention efforts. Some recommendations reflect expert opinions of the panel members, such as assumptions and hypotheses that drive certain prevention activities. Many represent "best practices" among prevention experts, while some recommendations relate to the implementation of specific prevention interventions.

Basis of Recommendations

These recommendations are based on the research and practice evidence reviewed in the Analysis of Evidence section, additional evidence not described in the section, and the professional experience and opinions of Expert Panel members. Many recommendations are derived from the experiences of Expert Panel members involved with research or practice activities that are not explicitly described in the chapter.

These recommendations represent the transfer of practical information from prevention research and practice experts to prevention decisionmakers, such as State and local prevention authorities, other prevention practitioners and researchers, and members of community prevention organizations.

A REQUEST TO READERS

Based on comments received from users of the first guideline, *Reducing Tobacco Use Among Youth: Community-Based Approaches*, several significant changes have been made in the structure and presentation of this publication. CSAP actively seeks a continuing dialogue with its constituents on the extent to which they find this series useful and the ways in which future guidelines may be improved. Therefore, comments are actively solicited for inclusion in revisions of this guideline or in production of future guidelines. They should be referred to PEPS Program Director, Division of State and Community Systems Development, Center for Substance Abuse Prevention, SAMHSA, 5600 Fishers Lane, Rockwall II, Rockville, MD 20857.

Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches

The Center for Substance Abuse Prevention (CSAP) created the Prevention Enhancement Protocols System (PEPS) to systematically identify current knowledge on prevention programs and to develop recommendations to guide and strengthen State prevention efforts. Under the PEPS program, panels of prevention experts have, for the first time, organized research and practice evidence on effective prevention programs into a set of guidelines and recommendations that meet the needs of practitioners. To date, one other PEPS guideline has been developed: *Reducing Tobacco Use Among Youth: Community-Based Approaches.* All of the PEPS documents will be accessible through CSAP's World Wide Web site at http://www.health.org.

Each guideline topic is presented in a set of three documents:

1. A comprehensive reference guide that describes in full the substance abuse topic to be evaluated, reviews research and practice information on the prevention approaches used to address the problem, analyzes the effectiveness of these approaches, discusses lessons learned, suggests a program design and method of implementation, and gives recommendations of the Expert Panel on developing effective prevention programs and designing research
2. A practitioner's guide that distills the guideline into an implementation-directed summary
3. A community guide, in brochure form, that practitioners may use to illustrate the rationale for their proposed prevention plans and to solicit community involvement and support

The practitioner's guide is a unique planning tool. It allows practitioners to:

1. Choose from among proven strategies and approaches to develop their own prevention programs
2. Learn to use a risk factor/protective factor approach to identify problems, collect data, and develop, carry out, and evaluate programs
3. Strengthen program effectiveness by using the "Developing and Delivering Family-Centered Approaches" section
4. Benefit from the evidence-based "Lessons Learned" drawn from the review and analysis of prevention research and practice evidence
5. Benefit from the "Recommendations for Practice" based on the expertise of the PEPS Expert Panel as well as the review of the research and practice evidence

WHY USE FAMILY-CENTERED APPROACHES? AREN'T OUR SCHOOL AND COMMUNITY EFFORTS SUFFICIENT?

Most Americans agree that the family is primarily responsible for ensuring the safety of children and for providing the nurturing and guidance children need. Skillful parenting helps children to become competent, caring adults who can live together peacefully and productively. In the past few decades, however, dramatic changes have taken place in American society and in the character of American family life (especially the role of women). Many of these changes can stress the family's ability to nurture healthy children and increase the likelihood that our youth, even at a very early age, will turn to substance abuse. Just listing some of these stress factors makes the challenge obvious:

1. *Economic deprivation*—For many economically deprived youth, drug trafficking and substance abuse have become the only perceived options for breaking the cycle of poverty and getting the goods and advantages their parents cannot afford to give them (Hawkins, Catalano, and Miller 1992).
2. *Homelessness*—Drug use by homeless and runaway youth in shelters was reported in one study in the southeastern United States to be two to seven times higher than in comparison school samples (Fors and Rojek 1991).
3. *Mothers in the workforce*—Working mothers have less time than nonworking mothers to spend with and monitor their children. Less maternal involvement is associated with an increased risk for behavior problems, conduct disorders, and substance abuse as the child approaches adolescence (Kandel and Andrews 1987).
4. *Single-parent families*—Children living in single-parent families are more likely than others to have emotional problems and academic difficulties, which in turn are risk factors for substance abuse (Emery 1988; McLanahan 1988; McLanahan and Sandefur 1994).

5. *Child abuse and neglect*—About 90 percent of the perpetrators of child maltreatment are parents and other relatives of the victims. In recent years, substance abuse by parents has come to be seen as a major cause of child abuse and neglect (National Center on Child Abuse and Neglect 1994).
6. *Teenaged mothers*—Teenaged mothers, many of whom lack adequate social support, are less capable than adult mothers of parenting and managing crises and may be more likely to turn to substance abuse to cope with stress (Department of Health and Human Services 1993).

The case for family-centered approaches is strong. While school- and community-based substance abuse prevention programs are essential, they are not sufficient. Frequently, schools do not begin addressing the substance abuse problem until adolescence, although the data indicate that the problem often begins in preadolescence. If families are to be successful in preventing substance abuse during the early years of a child's development, both parents and children need to develop the behaviors and skills that will enable them to manage themselves and their families in ways that support healthy growth. This training and support is all the more important today as a variety of stressors push and pull the family from every side.

Some families require only occasional support as specific problems arise. Others have greater difficulty and need ongoing support, and a small percentage of families who have a great need for resources and support have only a marginal capacity to find and use them. These families may need active assistance to protect the children and to help the parents impart the values and skills that will enable their children to succeed as adults.

HOW BIG A PROBLEM IS SUBSTANCE ABUSE AMONG YOUTH?

What do we know about our kids and substance abuse? Data on substance abuse among young children have not been systematically collected. However, the *Monitoring the Future Study* (University of Michigan Institute for Social Research 1997) shows that the use of illicit drugs by adolescents increased significantly between 1991 and 1996, representing a reversal of previous downward trends. By 1997, the resurgence showed signs of leveling off, especially among eighth-grade students.

Eighth-Grade Students

The percentage of eighth-grade students reporting any marijuana use in the past month increased from 3 percent in 1991 to 10 percent in 1997, down from 11 percent in 1996. The percentage reporting any cigarette use in the past month rose from 14 percent in 1991 to 19 percent in 1997, down from 21 percent in 1996. The percentage reporting any heroin use within the past month, although quite low, more than doubled from 0.3 percent in 1991 to 0.7 percent in 1996 before easing to 0.6 percent in 1997. Similarly, the percentage reporting any hallucinogen use rose from 0.8 percent in 1991 to 1.8 percent in 1997, also slightly lower than the year before. (University of Michigan Institute for Social Research 1997).

Box 1 illustrates the substance use experience of eighth-grade students as noted in the 1997 *Monitoring the Future Study.* All of these figures are slightly lower than the 1996 results.

BOX 1: Lifetime Substance Use by Eighth-Grade Students in 1997

In 1997, the percentages of eighth-grade students reporting the use of a substance of abuse at least once in their lifetime were reported as follows:

1. Alcohol—54 percent
2. Cigarettes—47 percent
3. Marijuana—23 percent
4. Inhalants—21 percent
5. Smokeless tobacco—17 percent
6. Stimulants—12 percent
7. Hallucinogens—5 percent
8. Cocaine—4 percent
9. Heroin—2 percent

(University of Michigan Institute for Social Research 1997)

Tenth-Grade Students

Of students in the tenth grade, the percentage reporting any marijuana use in the past month increased from 8 percent in 1992 to 21 percent in 1997. The percentage reporting any cigarette use in the past month rose from 21 percent in 1991 to 30 percent in 1997. The percentage reporting any heroin use within the past month is quite small but tripled from 0.2 percent in 1991 to 0.6 percent in 1997. Similarly, the percentage reporting any hallucinogen use doubled from 1.6 percent in 1991 to 3.3 percent in 1997 (University of Michigan Institute for Social Research 1997).

High School Seniors

The percentage of high school seniors reporting any illicit drug use in the past month was nearly 40 percent in 1979; it decreased to a low of 14 percent in 1992 but increased to 26 percent in 1997. Perhaps the most troubling increase involved marijuana. The percentage of high school seniors reporting marijuana use in the past month was 37 percent in 1979; it dropped to 12 percent in 1992 but rose to 24 percent in 1997. Similarly, the past-month use of cigarettes declined from a high of 38 percent in 1977 to a low of 28 percent in 1992. However, by 1997, the rate had increased to 37 percent (National Institute on Drug Abuse 1997; University of Michigan Institute for Social Research 1997).

High school seniors' reports of using a hallucinogen during the past month have fluctuated between 2 percent and 4 percent from 1975 through 1997. However, their rate of lifetime use of hallucinogens has risen from about 10 percent during the early 1990s to 15 percent in 1997, signaling an increase in experimentation (University of Michigan Institute for Social Research 1997).

The use of heroin by high school seniors has always been low, generally about 0.2 to 0.3 percent from the late 1970s through the early 1990s. However, though still less than 1 percent, the rate increased somewhat to 0.5 percent in 1997 (University of Michigan Institute for Social Research 1997).

Alcohol Use Remains High

In general, alcohol use among high school students has remained fairly stable in the past several years, although the rates are unacceptably high. Slightly more than half of high school seniors report drinking in the past month, a fairly consistent pattern in the 1990s. This rate is down from about 70 percent in the late 1970s and early 1980s. Even among eighth-grade students, more than half have tried alcohol, and a quarter report having had alcohol within the past month (University of Michigan Institute for Social Research 1997).

WHAT PUTS CHILDREN AND ADOLESCENTS AT RISK FOR SUBSTANCE ABUSE?

Researchers believe that to maximize the prevention of adolescent substance abuse, it is important both to reduce risks and to enhance protective factors.

Certain conditions—risk and protective factors—in the lives of some children and adolescents make it more or less likely that they will use alcohol, tobacco, or illicit drugs. Interaction of risk and protective factors within and among the three domains discussed below can affect the likelihood of adolescent substance abuse. For example,

a recent study concluded that, despite similar exposures to violence in their neighborhoods, children showed varying degrees of successful adaptation and behavioral problems. The impact of the risk factors in the community was lessened by the protective factors of family warmth, cohesion, and strong parenting (Richters and Martinez 1993). Similarly, high population density, overcrowding, and poor housing appear to contribute to antisocial behavior and delinquency—which, in turn, are known risk factors for substance abuse.

In general, risk and protective factors can be seen as operating in three areas of influence, or domains:

1. *Individual child factors of biology, behavior, and personality*
2. *Family factors*
3. *Environmental factors*

Risk and protective factors within each domain are listed below. While there are fewer identified protective factors than risk factors, their interaction with risk factors means that practitioners should always try to enhance them as they strive to reduce risk factors. However, doing so can be challenging because risk and protective factors are complex. In addition to the difficulties that may be posed by their number, intensity, and duration, risk and protective factors work within a dynamic and interactive system.

FAMILY-CENTERED APPROACHES TO PREVENTION OF SUBSTANCE ABUSE—WHAT WORKS

As PEPS evaluated research studies and practice cases, it grouped the evidence into three prevention approaches:

1. *Parent and family skills training*
2. *Family in-home support*
3. *Family therapy*

These approaches focus on the dynamics within the family as a whole and within a community—not merely the individual child within the family. Furthermore, these prevention approaches do not directly address substance abuse among youth. Rather, they address known risk and protective factors that increase or decrease the likelihood that children will begin—or continue—to abuse substances. It is also important to note that many approaches to preventing substance abuse in children and youth, including the three presented in this practitioner's guide, are based on the four developmental models (developmental pathways, social development, social ecology, and contextualism) defined in appendix B, which identify the ways risk and protective factors interact to shape children's lives.

The basic logic for reducing substance abuse is as depicted below:

Family-Centered Prevention Approaches → Reduce Risk Factors and Increase Protective Factors → Decrease Likelihood of Substance Abuse Among Youth

Each approach is presented below in terms of its underlying concept, the activities of the studies reviewed, the strength of the evidence supporting the approach, lessons learned from the evidence, and recommendations for practice based on the evidence, as well as the insight of the Expert Panel. General recommendations for practice follow presentation of the three approaches.

Risk and Protective Factors for Children and Adolescents

Individual Child Factors of Biology, Behavior, and Personality

Risk Factors	*Protective Factors*
1. Antisocial and other problem behaviors such as stealing, vandalism, conduct disorder, attention-deficit hyperactivity disorder (ADHA), rebelliousness, and aggressiveness—particularly in boys	1. Positive temperament
2. Alienation	2. Social coping skills
3. High tolerance for deviance and strong need for independence	3. Belief in one's own ability to exert control over what happens (self-efficacy) and in one's ability to adapt to changing circumstances
4. Psychopathology	4. Positive social orientation
5. Attitudes favorable to drug use	
6. High-risk personality factors such as sensation seeking, low harm avoidance, and poor impulse control	

Family Factors

Risk Factors	*Protective Factors*
1. Family behavior concerning substance abuse: a. Parental substance use and drug use modeling b. Perceived parental permissiveness of youth's substance use 2. Siblings' drug use, particularly that of older brothers 3. Poor family management and parenting practices: a. Overinvolvement of one parent and distancing by the other b. Low parental aspirations for children's educational achievement c. Unclear or unrealistic parental expectations for children's behavior, especially as they relate to the child's developmental level d. Poor disciplinary techniques, such as lack of or inconsistent discipline and extremely harsh punishment 4. Poor maternal-child relationships: a. Lack of maternal involvement in children's activities b. Cold, unresponsive, underprotective mother c. Low maternal attachment d. Maternal use of guilt to control children's behavior 5. Family conflict (a strong predictor of delinquency and antisocial behavior, including substance abuse) 6. Physical abuse (the earlier the age of experience, the greater its negative effects)	1. Cohesion, warmth, and attachment or bonding between parents and children during childhood 2. Parental supervision 3. Interaction and communication between and among parents, parents and children, and siblings

Environmental Factors

Risk Factors	*Protective Factors*
1. Peer influence—rejection or low acceptance, particularly in early school years	1. Sources of positive emotional support outside the family, such as close friends (one or several), neighbors, extended family, peers, and elders
2. Deficient cultural and social norms and laws, such as poor enforcement of minimum purchase age for alcohol and tobacco products, social norms condoning use, and proliferation of tobacco and alcohol product advertisements	2. Formal and informal supports and resources available to the family
3. Extreme poverty, for children with behavior problems and other risk factors	3. Community and school norms, beliefs, and behavioral standards against substance abuse
4. Neighborhood disorganization that reduces the sense of community, increases experiences with crime, and creates high mobility and transience	4. Successful school performance and strong commitment to school
5. Failure to achieve in school, especially in the late elementary grades, regardless of whether it is due to behavior problems, truancy, learning disabilities, poor school environment, or other causes	

Box 2 lists principles practitioners should follow in addressing the risk and protective factors on which the following prevention approaches are based.

Prevention Approach 1: Parent and Family Skills Training

Family functioning, structure, and values have a significant impact on children's capacity to develop prosocial skills and cope with life's challenges. Parent and family skills training can provide parents and family members with new skills. These skills enable families to better nurture and protect their children, help children develop prosocial behaviors, and train families to deal with particularly challenging children.

This prevention approach addresses two clusters based on the risk levels of the target populations:

1. Families with children who are not known to have risk factors *and* families with children who are exposed to risk factors and are therefore at above-average risk. Common risks might include being in a single-parent family, a family in economic distress, or a family of divorce.

2. Families with children who are at high risk because they are exposed to multiple risk factors or have a high level of exposure to a single risk factor. Examples might be children identified as having serious behavior problems, as being delinquent, as having substance-abusing parents, or as being victims of child abuse.

The risks faced by families in the first cluster call for *universal* or *selective* prevention measures, as defined in the Institute of Medicine's (IOM's) classification system. *Indicated* prevention measures are appropriate for the second cluster (Gordon 1983, 1987; Institute of Medicine 1994).

Because the activities and levels of evidence are unique to each cluster, they are presented separately below. The lessons learned and recommendations for practice that follow apply to both clusters.

BOX 2: How Can Practitioners Have the Greatest Impact?

In addressing the various risk and protective factors around which family-centered approaches are built, practitioners should keep in mind the following principles:

1. Select prevention approaches according to the risk level of the targeted families. Differentiate among:
   a. Families not yet known to have any risk factors,
   b. Families with children who belong to subgroups that have risk factors for substance abuse but do not yet use substances, and
   c. Families with children who already are known to have such risk factors as antisocial behavior and conduct disorder.

Respectively, risk levels a, b, and c represent the population groups to which three categories of prevention activities (universal, selective, or indicated) should be directed (Gordon 1983, 1987; Institute of Medicine 1994).

2. Focus on families with young, school-aged children (before negative behaviors and family problems become entrenched).
3. Reduce exposure to risks.
4. Enhance protective factors.
5. Choose strategies that are developmentally and gender appropriate.
6. Develop interventions in multiple contexts and settings (e.g., schools, cultural life, religious institutions, neighborhoods, and communities).
7. Address multiple risk factors simultaneously (e.g., working to reduce domestic conflict and children's antisocial behavior while improving parenting skills and school performance).
8. Build on families' strengths, preserve their integrity (including their language and culture), and encourage their leadership in the growth process.

Expected Changes and Key Activities for Approach 1

Cluster 1. This cluster, as noted above, includes families with children who have no known risk factors. As noted earlier, according to the IOM's classification system, ***universal preventive measures*** are appropriate for these families. Cluster 1 also includes families with children who are exposed to risk factors and are therefore at above-average risk. *Selective preventive measures* are appropriate for these families.

The parent and family training activities or interventions in this cluster include some training sessions that involve the child and other family members and others that are parent oriented. All of the activities focus on changes in:

1. *Parents*—Acquiring or improving parenting skills, child management abilities, psychological helping skills, relationship development, and empathy
2. *Families*—Improving family cohesion, organization, relationships, and conflict resolution
3. *Youth*—Improving general child behavior, psychological adjustments, attachment to family, and commitment to school

Activities include:

1. Didactic presentations, both live and videotaped, followed by discussions
2. Role-playing and skills practice sessions
3. Curriculum-based training to recognize and modify risk and protective factors
4. Modeling sessions on interaction, communication, and crisis handling
5. Cognitive-behavioral workshops and multisession training programs

(See box 3 for the levels of evidence for this cluster.)

BOX 3: Levels of Evidence—Approach 1

Cluster 1

For families with children who are not known to have risk factors *and* for families with children who are exposed to risk factors, the research and practice evidence reviewed indicates that it is possible to implement parent and family skills training interventions:

- There is **strong evidence** that these interventions can stabilize or improve the conditions that decrease risk factors for substance abuse, such as poor parent-child communication, child problem behavior, inadequate parenting skills, poor family relationships, parental substance use, family conflict, and family disorganization.
- There is **suggestive but insufficient evidence** that, when specifically directed, these interventions can improve children's social skills and prosocial behavior.
- There is **suggestive but insufficient evidence** that, when specifically directed, these interventions can reduce parental stress and depression, improve children's self-esteem, and promote improvements related to differences in social assimilation between parents and children.
- There is **suggestive but insufficient evidence** that using a combination of parent training, children's social skills training, and family relationship training leads to greater improvements overall in parent-child relationships than would any of these interventions alone.

Cluster 2

For families with children who are at high risk for substance abuse because they either are exposed to multiple risk factors or have a high-level exposure to a single risk factor, such as conduct disorder, the research and practice evidence indicates that it is possible to implement parent and family skills training interventions:

- There is **strong evidence** that these interventions can decrease risk factors such as child problem behavior and poor parenting skills and increase protective factors such as healthy family communication, bonding, and conflict resolution.
- There is **suggestive but insufficient evidence** that these interventions reduce parents' stress, depression, and substance use; improve children's self-esteem; and promote improvements related to differences in social assimilation between parents and children.
- There is **strong evidence** that these interventions have a positive and lasting effect in improving parenting skills and behaviors as well as reducing diagnosed problem behaviors in children.

NOTE: The criteria used to rate the strength of evidence for each prevention approach are shown in appendix A.

Cluster 2. As noted above, this cluster includes families with children at high risk for substance abuse because they are exposed to multiple risks or have a high level of exposure to a single factor, such as conduct disorder. *Indicated preventive measures* are appropriate for these families (Institute of Medicine 1994).

The parent and family training activities or interventions examined in this cluster include parent training without child involvement, parent training with separate child training, family skills training, and parent training plus family skills training.

All of the activities focus on changes in:

1. *Parents*—Improving parents' attitudes toward their children, aquiring or improving parenting skills, child management abilities, problem-solving skills, communication skills, and crisis management abilities
2. *Youth*—Improving general behavior, acquiring or improving self-control and compliance, reducing antisocial and other problem behaviors, and reducing arrest rates

Activities include:

1. Videotaped modeling sessions, with and without counseling and practice
2. Manual-based training, with and without discussions
3. Didactic, role-playing, and skill practice sessions
4. Cognitive-behavioral and problem-solving skills training
5. Behavioral parent training
6. Parent and teacher training
7. Structural family therapy and family effectiveness training
8. Parent counseling
9. Individual and group therapy for parents, both with and without children

(See box 3 for the levels of evidence for this cluster.)

Lessons Learned for Approach 1

1. Research demonstrates that parent and family skills training can greatly benefit parents, the family, and children:
   a. Parents increased their knowledge, parenting skills, problem-solving skills, child management skills, and coping skills and improved their attitudes, including acceptance of their children.
   b. Parent-child relations showed increased family cohesion and decreased family problem behaviors, family conflicts, and substance abuse.
   c. Children showed increased prosocial behaviors and decreased hyperactivity, social withdrawal, aggression, and delinquency.

2. Research suggests that increased parental effectiveness is associated with their decreased use of substances. The causal direction of this relationship, however, is unknown:
    a. Some positive effects may be due to children's exerting pressure on parents to stop substance use.
    b. It is also likely that some changes are due to improved communication skills and an increased parental awareness of the effects of their drug use on family dynamics.
3. Research suggests that parent and family training may have an impact on parents being treated for substance abuse that is above and beyond the treatment effect:
    a. This may be particularly true for women who increase their ability to communicate and manage their families effectively.
    b. Adding parent and family training to addiction treatment may also reduce the likelihood of relapse.
4. Research suggests that the more competent the trainer (e.g., having good group process skills) and the better he or she is able to relate to parents and family members, the more likely it is that parents will enter the programs and master higher functioning skills.
5. Research suggests that videotaped training and modeling, when combined with group discussion and a therapist's consultation, can be an effective and economical way to teach new behaviors and skills.

Recommendations for Practice for Approach 1

The PEPS Expert Panel also made recommendations regarding parent and family skills training based on members' experience and their interpretation of the research and practice evidence. The panel's recommendations focused on the benefits of combining parent training and children's skills training with family therapy, cultural content, environmental context, multicomponent programs, and efforts to retain participants:

1. Combining parent training and children's skills training with family therapy addresses a broader array of family risk and protective factors for substance abuse and helps prevent "family sabotage effects" that emerge when only the individual child or parent is treated.
2. Parent and family skills training is easier to implement than family skills therapy because it is highly structured and requires fewer skills. It is also easier to adapt to meet ethnic, cultural, regional, and child developmental stages.
3. Parent and family skills training programs should incorporate cultural content. Specifically, culture can serve as the core around which changes in family dynamics and roles can be initiated through parent and family skills training interventions.

Training programs should identify, build on, and measure the intervention's ability to maximize the family's cultural strengths.

4. When parents do not succeed in parent and family skills training, it is important to consider more than the training class itself. Other serious problems in the family and environment might be affecting the parents' ability to learn. Consider factors such as home violence, unsafe neighborhood, and poverty-related stresses.
5. For greater success, address multiple family and community contexts, such as reducing social isolation, building peer support networks, increasing awareness of community resources, and coping with depression and parenting stress. When possible, use an integrated family-school strategy.
6. Research demonstrates that parents of children with conduct problems, even those with multiple problems, are often successfully retained in parent training. This is in contrast to an opinion frequently expressed by prevention specialists that such retention is nearly impossible. It may be that parent training promotes participant retention because parents view it as a helpful and acceptable form of intervention, or it may be that it increases the parents' hope and sense of competence.
7. Parent training interventions for children with conduct problems are more effective with younger children than with older children. Prevention programs should incorporate the concept that early intervention is best.

(General recommendations are listed on pages 20-22 immediately following the presentation of approaches.)

Prevention Approach 2: Family In-Home Support

This prevention approach targets families who are at high risk because they face multiple risk factors or have a high level of exposure to one risk factor. According to the Institute of Medicine's framework, *indicated preventive measures* are appropriate for these families.

These families are more likely than others to fall apart and have children placed outside the home. In-home support addresses these risks simultaneously and tailors its interventions to the family's unique situation. Intensive and comprehensive services provided for several months to a year can help stabilize the family and enhance the parents' ability to nurture and protect their children. Among the most common goals of family in-home support is decreasing the likelihood of domestic violence, child abuse, or neglect and preventing placement of children in foster homes or institutions for juvenile delinquents (Kinney et al. 1990).

Expected Changes and Key Activities for Approach 2

The primary objective of in-home prevention interventions is to preserve families so they can nurture, protect, and teach their children to become capable, competent, and caring adults. All activities focus on changes in:

1. *Parents*—Acquiring or improving parenting skills related to discipline, family relations, communication, and anger management and for decreasing the likelihood of child abuse and/or neglect
2 *Youth*—Training in communication skills and anger management, increasing compliance with curfew and school attendance, and diminishing the rates of arrests and criminal activities among juvenile offenders
3. *Families*—Preventing children from being removed from the family, and reuniting previously removed children with their families

Activities include:

1. *Direct services*—Transportation, cash assistance, clothing, food, help with home repairs, etc.
2. *Social services*—Individual and family counseling, crisis intervention, behavior management training, substance abuse referrals for treatment, case management services, and reuniting children with their families after outside placement

BOX 4: Levels of Evidence—Approach 2

The research evidence reviewed concentrates on in-home support services as indicated preventive measures—comprehensive, intensive, multipurpose services provided in the home and designed to address a range of family problems, typically involving all family members.

The research and practice evidence reviewed indicates that it is possible to implement in-home support services as indicated preventive measures:

- There is **medium evidence** that multisystemic therapy, provided in the home, is effective in reducing juvenile criminal activity and rearrest.
- There is **medium evidence** that multisystemic therapy, provided in the home, is effective in improving family characteristics associated with juvenile antisocial behavior, such as family cohesion and symptomatology.
- There is **medium evidence** that home-based family preservation services are effective in avoiding out-of-home placement and reducing the number of days of placement.

NOTE: The criteria used to rate the strength of evidence for each prevention approach are shown in appendix A.

Lessons Learned for Approach 2

1. The level of evidence is not strong. Practitioners need to be aware that although use of the in-home support services prevention approach is currently in favor, there is a dearth of controlled studies. One reason is the ethical issue of assigning families with identified needs and problems to a nontreatment control group.
2. The use of comparison treatment conditions as a control group is underutilized.
3. Only very broad conclusions can be reached regarding the provision of services and the effect of an intervention on families. This is due to a number of reasons, among them the scarcity of experimental studies having a common focus and the difficulty of designing research that:
    a. Teases out the differing effects of particular elements, such as different facets of an intervention
    b. Examines whether there is a priority of needs
    c. Measures the interrelationships of specific elements of the intervention and specific outcomes

Recommendations for Practice for Approach 2

The PEPS Expert Panel's recommendations for in-home support services were based on members' experience and interpretation of the research findings. The panel focused on family-centered assessments, strength-based assessments, fragmentation of services, use of neighborhood-based family workers, and a variety of family preservation efforts:

1. Families should be encouraged to become partners in any assessment of family needs in the community. Assessments should include the family's perspectives on both the nature of the problems and the ways those problems should be solved. Assessments should reflect the family's perceptions of its needs, problems, goals, objectives, and timelines. Including the family in this process is in itself an intervention that increases its ability to manage and make decisions.
2. Include family contexts and informal supports, such as involvement of members of the extended family and churches, in assessments and services plans.
3. Experience suggests that assessments and services plans are more useful when they focus not only on problems but also on the strengths, competencies, and capabilities that help the family survive. When a family's strengths are enhanced and weaknesses reduced, its capacity to thrive grows. The evaluation of family strengths should include the family's readiness to change and the parents' ability to invest in learning parenting skills.

4. Families in crisis may need numerous health and social services at times when they are least able to find and gain access to them. Often the services they need are fragmented and compartmentalized. Families must work with several provider representatives and fill out duplicative agency-specific paperwork. During crisis, families need integrated and comprehensive resources. Any effort to simplify the process should have a significant impact on the ability of families in crisis to obtain the help they need.
5. Neighborhood-based family workers should be recruited to form a bridge between agencies and families. Such workers help both families and agencies integrate and manage the services received. They help care providers form alliances with formal and informal support networks in the community that can in turn strengthen family functioning. Such workers also provide ongoing emotional support and a consistent flow of accurate information.

(General recommendations are listed immediately following the presentation of approaches.)

Prevention Approach 3: Family Therapy

Like the second prevention approach, "in-home services," this prevention approach targets families at high risk because they face multiple risk factors or have a high level of exposure to a particular risk factor. The interventions in this approach are designed to improve family functioning and reduce juvenile delinquency, recidivism, child abuse, and other strong antisocial behaviors.

Family therapy helps family members develop interpersonal skills and improve communication, family dynamics, and interpersonal behavior. It can be used to help family members improve their perceptions about one another, decrease negative behavior, and create skills for healthy family interaction. It can also be used to enhance parenting skills and reduce inappropriate parental control over children.

Expected Changes and Key Activities for Approach 3

The expected changes in this prevention approach all focus on improving family functioning and reducing children's recidivism and other problem behaviors.

All activities focus on changes in:

1. *Families*—Increasing mutual positive reinforcement and decreasing maladaptive interaction patterns; improving family dynamics in families with juvenile offenders or adolescents with strong antisocial behaviors; acquiring skills, improving communication, learning effective discipline methods, and learning self-management skills

2. *Youth*—Reducing behavioral and emotional problems and repeat offender rates, improving the functioning of juvenile offenders, and preventing the initiation of substance abuse

Activities include various types of family-centered therapies used with diverse groups of clients. The following illustrate some of the therapies and groups treated:

1. Functional family therapy, used by paraprofessional therapists and foster care caseworkers for families with seriously delinquent youth (Alexander and Parsons 1982)
2. Structural family therapy, used for Hispanic families with boys diagnosed as having opposition disorder, conduct disorder, adjustment disorder, or anxiety disorder (Santisteban et al. 1995)
3. Multisystemic family-ecological therapy for families with juvenile offenders (Henggeler et al. 1986; Henggeler, Melton, and Smith 1992)

(See box 5 for levels of evidence for this approach.)

BOX 5: Levels of Evidence—Approach 3

The research and practice evidence reviewed indicates that it is possible to implement family therapy for families with children who are at high risk of substance abuse:

- There is **medium evidence** that family therapy results in enhanced parenting skills, improved family communication, increased parental knowledge about how to reduce antisocial child behavior, improved perceptions and attitudes of parents and adolescents about each other, and reduced inappropriate control of parents over adolescents.
- There is **strong evidence** that family therapy reduces recidivism in delinquent teenagers.

NOTE: The criteria used to rate the strength of evidence for each prevention approach are shown in appendix A.

Lessons Learned for Approach 3

1. Research demonstrates that family therapy is an effective resource for improving family functioning, increasing parenting skills, and decreasing the recidivism of juvenile offenders.
2. Most empirical investigations of family therapy have focused on families with adolescents, many of whom are juvenile offenders. These youth are often much more difficult to influence and have moderate to severe disorders. The impact of family therapy in families with younger children and less severe behavior problems needs to be thoroughly investigated.

3. Research and practice demonstrate that family therapy can be part of a multicomponent prevention effort. For instance, family therapy can be a component in prevention efforts that include in-home family support and school-based problem-solving counseling.

Recommendations for Practice for Approach 3

The PEPS Expert Panel members made recommendations regarding family therapy based on their experience and their interpretation of the research and practice evidence. The panel focused on interagency collaboration, participant recruitment and retention, cultural context, and interventions appropriate to the developmental level of young children:

1. Because families in crisis are likely to receive services from multiple agencies, family therapy providers should be linked with social and other services agencies. Interagency collaboration and coordination and integrated case management are essential. Formal and informal agreements, including memorandums of understanding, case management meetings, and regular multidisciplinary interagency trainings, are helpful. A special contract or some other mechanism is necessary to spell out roles and services such as joint referral, intake, and assessment procedures.
2. Family therapy is still viewed very negatively among people from some regions of the country and among certain ethnic and socioeconomic groups. This makes recruitment and retention in family therapy difficult. The intervention design needs to address educating the target population to increase their positive regard for family therapy. Neighborhood volunteers and community outreach workers can be trained to give lectures on depression, anxiety, substance abuse, and child problem behaviors to help demystify family therapy. These activities, offered in collaboration with churches, schools, and community centers, can serve as a way to recruit families into therapy.
3. Practitioners should understand the cultural values, beliefs, and traditions of the families they serve. They should also be familiar with the resources available in the community where the family lives.
4. Family therapy that requires a participant's understanding of complex family and interpersonal dynamics may not be appropriate for young children. When children are to be participants, interventions should be chosen that are appropriate to their developmental level (e.g., family play therapy for families with young children).

GENERAL RECOMMENDATIONS ON FAMILY-CENTERED APPROACHES

1. Family-centered prevention services are not likely to be successful for families with significant unmet needs related to food, shelter, employment, literacy, and physical and mental health. Prevention practitioners need to either supply the necessary

services or help families get them. Basic needs must be met during and after intervention if the prevention program is to be successful.

2. It is unrealistic to expect that a short-term (e.g., 10 to 14 sessions) intervention involving parent training, family skills training, or family therapy will provide a "single-shot cure." This is especially true for children with severe or chronic behavioral problems in difficult family and community contexts. It is more realistic to use repeated "booster" interventions tailored to the major stages of a child's development. It is advisable to consider using other types of interventions before, during, and after or in place of the family-centered intervention. Student counseling, psychiatric interventions, self-help programs, and other educational services help sustain the behavior change process over time.
3. Whenever possible, prevention interventions should be conducted in settings and locations that are comfortable, natural, and easily accessible to parents and children. It is ideal to bring the intervention to the target population, using their schools, workplaces, homes, churches, and community centers.
4. Family-centered approaches are highly compatible with and can be easily integrated into most substance abuse prevention programs. For example, school-based interventions could include a parent and family skills training component or even family therapy interventions. Doing so would strengthen both programs.
5. Family-centered interventions can be made more attractive and accessible by providing vital services that remove barriers to participation, such as transportation, child care, and meals.
6. When community support is sought, family-centered interventions can be more easily integrated into the community. This might involve community outreach to educate relevant community leaders, such as ministers, physicians, and educators, and conducting focus groups and other community education efforts.
7. There is a tremendous need to build and sustain active partnerships between prevention practitioners and researchers. Both groups have skills, knowledge, and expertise to share. Good practice programs are based on the latest research. If advances in knowledge are to be made, researchers need the help of practitioners in designing and implementing studies that capitalize not only on their valuable input, but also on that of local community experts, residents, and parents. Researchers, in turn, continue to seek answers to the many questions that plague the practitioner in designing and implementing prevention programs.
8. Especially when involved in community education, prevention experts should not present themselves as authorities who identify problems in others and then provide the answers "from above." They need to assume the role of information provider and resource expert by:

    a. Providing information on a variety of health and mental health issues
    b. Teaching families to recognize when a problem requires professional attention

c. Providing information on options and resources in the community
d. Teaching families how to gain access to resources

Understanding the effectiveness of each prevention approach requires a thorough comprehension of the rating system used. For help in understanding the level-of-evidence statements used to assess the particular effects of each prevention approach, practitioners should refer to box 6.

PROGRAM DEVELOPMENT AND DELIVERY OF FAMILY-CENTERED APPROACHES

The reference guide from which this document is derived, *Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches,* has a detailed and extremely helpful presentation on program development, delivery, and evaluation. Practitioners are encouraged to examine that section of the full guideline very carefully.

The material presented in this section contains:

1. A detailed planning table entitled "Specific Tasks and Activities of Program Development." The table lists the basic activities and tasks for the four steps of program development:
   a. Assessment
   b. Planning
   c. Delivery
   d. Evaluation
2. Special planning issues for family-centered approaches include:
   a. A discussion on ways to relate demographic information to risk and protective factors and to table 2, Community and Family Data Organized by Risk and Protective Factors, with suggestions for doing so
   b. Ideas and suggestions for creating a partnership with potential program participants and the target community to keep them involved in every step of prevention intervention development and delivery
   c. A brief discussion on identifying community resources
   d. Ways to define the problem using a risk and protective factor approach

At this point, readers would do well to review box 2, "How Can Practitioners Have the Greatest Impact?" presented earlier in this guide. Those observations were presented to provide an overview or sense of the "big picture." Reviewing them at this point will set the framework for the following material.

Specific Tasks and Activities of Program Development

Table 1, Specific Tasks and Activities of Program Development, lists the four primary steps essential to the development of any prevention program: assessment, plan-

BOX 6: Using Levels of Evidence To Guide Your Program Planning

The PEPS Expert Panel, as it reviewed the research and practice evidence, used a set of preestablished criteria to rate the relative strength of evidence based on the rigor of the studies and the number of studies with similar findings. These level-of-evidence statements should help practitioners confidently select approaches and specific interventions according to the demonstrated effectiveness of each strategy.

Because prevention activities vary in their emphasis, scope, and content, no two research studies or practice cases are the same. They differ in what they evaluate and the methods used. This can make it difficult to reach a single conclusion about any particular approach. Therefore, several evidence statements may be created to identify and rate the specific conclusions that can be drawn about a prevention approach, as shown by similar findings from more than one study. For instance, studies may show that a prevention approach has *strong evidence* for attaining a desired effect in the short term but *suggestive but insufficient evidence* for sustaining that effect over time.

Strong evidence means that given the current state of the art, practitioners can use a prevention approach with the most assurance that the approach can produce the particular effect specified in the evidence statement.

Medium evidence means that although the number of the studies reviewed is limited, there is still substantial support for a prevention approach's ability to produce the particular effect specified in the evidence statement. Practitioners may still use it but should have social, logistic, economic, political, or other reasons to choose this approach.

Suggestive but insufficient evidence means that the prevention approach has shown promise for the particular effect specified but should still be regarded as not well demonstrated. Practitioners should be cautious about undertaking approaches with this level of evidence. However, depending on circumstances, the approach might fit the local situation but would clearly merit further substantial documentation and evaluation of effects. If contradictory results are reported by the studies reviewed, caution should be used in selecting intervention(s) within an approach.

Substantial evidence of ineffectiveness means that the approach has not demonstrated the intended results or has shown negative findings for the particular effect specified. Practitioners should avoid these approaches, as they offer no promise of success at present.

All of the prevention approaches falling within the strong evidence category in this guide should be considered. In certain circumstances, approaches with a strong level of evidence for the particular effect sought by practitioners may not be feasible. Local needs, interests, resources, and abilities—as well as the level of evidence—must all be considered as practitioners make their program development choices.

ning, delivery, and evaluation. Both the tasks and the activities involved in accomplishing each step are specifically tailored to the challenge of planning and implementing a family-centered prevention intervention.

Table 1 can serve as a checklist for good planning. An expanded treatment of each item is provided in the full guideline.

TABLE 1: Specific Tasks and Activities of Program Development

Step in Program Development	*Tasks*	*Activities*
Step 1: Assessment	Develop a family and community profile of risk and protective factors	Gather information on demographics and other social indicators
		Gather descriptive information (surveys, interviews, meetings)
		Include formal and informal sources
	Define the problem	Compare assessment information with risk and protective factors specified on pages 7–9
	Choose target families and prevention approaches	Determine where problem has the greatest impact on families
		Assess interests, needs, concerns, and issues of families and their acceptance of potential approach(es)
		Assess extent of support and resources from community partners
	Assess characteristics of target families that will affect their participation	Understand and respond to family cultures and values
		Understand and respond to parental attitudes and beliefs
	Establish a process for involving families and community partners	(See above activities)
Step 2: Planning	Plan partnerships with parents and community collaborators	Identify barriers to recruitment of families
		Identify barriers to their participation
		1. Lack of awareness of benefits
		2. Cultural barriers
		3. Support for basic needs
		4. Negative views of approaches
		5. Work site barriers
		6. Characteristics and settings
	Address the needs of the targeted children	Fit intervention to age, gender, and developmental stage of children from participating target families

Step in Program Development	*Tasks*	*Activities*
Step 3: Delivery	Hire and support staff	Develop staff hiring criteria (e.g., expertise, training, interpersonal skills)
		Develop hiring criteria specifically for facilitators and therapists
		Train facilitators
		Provide staff support (e.g., team building, facilitator meetings)
	Deliver the intervention in a partner relationship with parents	Involve parents in the delivery of the intervention
		Encourage dialogue between parents and facilitators
		Use parent "graduates" of the program in leadership roles
	Develop strategies to monitor and retain participants	Establish and publicize incentives for participation
		Monitor participant response and reasons for not participating
		Maintain referral network for basic support
Step 4: Evaluation	Consult with evaluation experts	Consider options and choose the most appropriate and feasible evaluation
	Involve participants, staff, and other community stakeholders in the evaluation process	Offer opportunities to participate in the evaluation design
	Consider a variety of methods and measures to evaluate process and outcomes	Choose evaluation methods and measures that accommodate the activities of the intervention and the budget
	Identify data sources and develop procedures for collecting data	Develop unambiguous definitions of what is to be measured and explain to staff
		Identify such sources as assessments, client attendance, and feedback
		Ensure similar recording of data among different facilitators/therapists
	Consider cost factors	Determine scope of evaluation design needed to accomplish purpose and achieve outcomes of evaluation
		Document significant improvements in outcomes
		Outline cost of activities to determine barriers to recruitment and participation
		Determine length of evaluation

Special Planning Issues

Collecting and Organizing Data by Risk and Protective Factors

To select the most appropriate family-centered approach for a given community, *it is vital to identify the specific problems and community needs that increase the risk of adolescent substance abuse as well as the assets or strengths that protect against or reduce these risks.* By creating a community profile that organizes data around risk and protective factors, program developers can highlight community and family characteristics that seem to have the greatest correlation with substance abuse. (See table 2, Community and Family Data Organized by Risk and Protective Factors.)

Members of the target population and community—especially parents, children, and adolescents—should be enlisted to help gather and analyze community and family information. *Whatever methods are chosen to gather the data for a community profile, it is essential to involve families who are likely to participate in the family-centered interventions.*

Seek the opinions and ideas of a wide variety of people who live in the community. Use telephone interviews, focus groups, written surveys, community meetings, and personal interviews. Include community members of various socioeconomic levels, cultures, languages, and neighborhoods in gathering and analyzing information.

TABLE 2: Community and Family Data Organized by Risk and Protective Factors

	Community and Family Indicators	
Social Conditions	*Risks*	*Protective Factors*
Economic status of families	Rate of families living in poverty	Rate of families living in poverty who have successfully raised their children to be productive adults Rate of parents who have achieved economic self-sufficiency Availability of community programs to assist parents with achieving economic self-sufficiency
Neighborhood organization	Violence and crime rates, including rates of juvenile delinquency and homicide among youth Rate of suicide among children and adolescents	Number of programs in high-risk communities that work with children and adolescents Counseling resources available for children and adolescents Number of neighborhoods that have banded together to make improvements Availability of child care resources Presence of housing opportunities for low-income families

	Community and Family Indicators	
Social Conditions	*Risks*	*Protective Factors*
Social behavior of children and adolescents	Rate of children and adolescents with diagnosed conduct and other problem behaviors	Availability of therapy resources for children and families
	Violence and crime rates, including juvenile delinquency	Availability of juvenile court rehabilitation resources
	Rate of children living in poverty	Availability of alternative school programs and meaningful vocational education opportunities
	Rate of unemployment among young adults	Rate of low-income children enrolled in programs for high achievers, gifted/talented programs
Family management and parenting practices	Rate of teenaged parents	Parent and family skills training programs available to all families and to high-risk families
		Number of home visitation programs and other resources for new or young parents
		Presence of parent self-help groups
Family behavior concerning substance abuse	Rate of adult alcohol and drug abusers	Availability of substance abuse prevention programs for families
	Rate of adolescent substance abusers (alcohol, tobacco, illicit drugs)	Availability of treatment programs for parents and children
		Community laws and norms regarding adolescents' access to and abuse of substances
Physical treatment of child	Rates of child abuse and out-of-home placement	Availability and adequacy of family preservation programs
		Percentage of children available for adoption who are adopted
		Presence of child abuse prevention programs in the community
Failure to achieve in school	Rate of school dropouts	Availability of special education services, tutoring, counseling, etc., for children and adolescents
	Rate of students who fail required achievement tests or grades	Availability of alternative education opportunities
	Rate of runaway and homeless youth	Availability of shelters and services for runaway and homeless youth
Parental monitoring	Rate of working mothers	Availability of after-school care for children of all working parents
	Rate of parents who do not participate in school events for parents, including conferences	Flexibility of hours in school and other community programs
	Rate of children who are not in supervised after-school programs	Adequacy and safety of public transportation systems for adolescents
	Rate of children who are at home alone after school, by age	

TABLE 2 (continued): Community and Family Data Organized by Risk and Protective Factors

	Community and Family Indicators	
Social Conditions	*Risks*	*Protective Factors*
Parental monitoring (continued)	Physical and mental health status of children, including those with developmental delay, learning disabilities, and emotional or behavioral problems	
Family bonding		Low-cost opportunities in communities for various family activities
		Availability of family support programs for all families and for high-risk families

NOTE: Wherever possible, information on these indicators should be gathered according to culture and ethnicity as well as geographic or neighborhood distribution

Establishing a Process for Involving Families and Communities as Partners

The key to success in family-centered approaches is building in, at each stage of development, strategies that involve the participants in planning and decisionmaking. When this is done, the design and implementation of the intervention will be more likely to match the needs, strengths, and expectations of those it serves. In other words, and to reemphasize, *involve participants and community leaders in each of these activities:*

1. Assessment
    a. Information gathering, problem definition, and target population selection
    b. Analysis of the cultural values and parental attitudes and beliefs that relate to the substance abuse problem and their capacity to affect that problem
2. Planning
    a. Building opportunities for parent participation in planning
    b. Ensuring that practitioners really listen to parents' goals and expectations
    c. Designing programs that reflect the cultures of and diversity in the target families
    d. Designing interventions that integrate the families' natural helping networks
    e. Developing a core of community organizations that collaborate to provide a "safety net" of services to meet the basic needs of participating families
    f. Identifying barriers to recruitment and participation from the community's perspective
    g. Developing strategies to overcome these barriers so that the community is aware of the benefits of the program, feels the program is sensitive to differing cultures, and offers training that will help community members deal more effectively with their family problems

3. Delivery
    a. Serving as support staff and paraprofessional trainers
    b. Helping with logistics and food serving
    c. Serving as language or cultural translators
    d. Encouraging dialogue between parents and facilitators
    e. Using "graduate parents" in leadership roles to motivate others to participate, contact dropouts, and serve as consultants in the replanning and delivery of the intervention
    f. Developing strategies to monitor and retain participants
    g. Establishing and publicizing incentives for participation, such as free transportation and child care, snacks or meals during intervention activities, free coupons for food or video rentals, "graduation" gifts, parties or family outings, access to clothing and food banks, and referral services for legal, medical, housing, and financial aid
    h. Maintaining a referral network for basic family support and monitoring it to identify breakdowns in collaboration and coordination that reduce the family's ability to participate in the intervention
4. Evaluation
    a. Designing a "stakeholders" evaluation specific to the community being served
    b. Working with the project evaluator to hold focus group meetings with potential participants to overcome their reluctance to be involved in programs that include evaluations
    c. Involving participants in the collection of participation rate data for a program to increase their willingness to evaluate it

Program developers, trainers, social workers, and psychologists have conducted conduct assessments and implemented solutions based on what they think is best for the family. With this approach, families rarely have an opportunity to express their ideas about their own needs or to collaborate in the development of a program. It stands to reason that a program designed by "outsiders" will not have the same "fit," participation rate, or effect as one designed with the collaboration and input of the target population. The more involved members of the target community become in the planning and delivery of a program, the more likely they are to use it to their benefit.

Defining the Problem Using a Risk-and-Protective-Factor Approach

Once the assessment of the community's risk and protective factors is completed, practitioners can work with community partners to analyze the collected information. They will need to identify the most prominent substance abuse problems among children and adolescents in the community and the risk and protective factors that are most clearly associated with those problems.

Substance abuse problems are often hidden or silent. Even statistical data and anecdotal information may not make the problem visible to the community or give a clear outline of its extent. Risk and protective factors can function like clues, pointing out problems that increase the likelihood of substance abuse and factors that help to prevent it. The risk and protective factors outlined earlier are valuable in determining when there is a need to intervene.

Most likely, practitioners will identify several key problems during the assessment. But how can priorities be set so that a plan can be developed? Sometimes the seriousness of the problem and the resources available determine what needs to be done first. *One of the most important resources is members of the community who are willing and available to work with practitioners on the problem.*

Program developers may want to start with an easy problem to build community support around a successful undertaking. To others, it may seem best to plan a complex, multiproblem strategy that will take full advantage of the resources the community already has in place. Practitioners should know that it is vital to involve community members in identifying the problem so they will develop ownership in the solution.

Community mapping is an important tool for analyzing the scope of community problems:

- In a neighborhood needs map, identify areas with negative community factors, such as unemployment, gangs, and child abuse. Fill in demographic and descriptive information pertaining to these areas.
- In a community assets map, identify community strengths, such as parks, cultural groups, businesses, and religious institutions. Provide demographic and descriptive information pertaining to these areas. Community planners often forget about neighborhood assets and how they can provide support for children and families.

(For more information on community mapping, see the reference guide.)

Defining the problem includes selecting a target population. Questions to ask at this time are:

- Does the problem have its greatest impact on all families in the community or only a certain group of families who are at above-average risk for adolescent substance abuse?
- What was learned during the assessment that might help in selecting the target population? Ask these questions:
  1. Would participation be increased by offering intervention to all families instead of singling out families?
  2. How would high-risk families respond to the availability of extra support?

3. Which families at risk bring other special strengths and therefore might be more successful?

The more help practitioners have from the community in identifying target families, designing the intervention, providing collateral support services, and funding the intervention, the more likely they are to succeed.

Identifying Community Resources

Include any and all resources that might support the target families and the community that the prevention approach will serve. Contact such resources and learn how the prevention approach can be coordinated with the support they provide.

In many cases, community resources that support families are outside the obvious formal and traditional sources, such as schools, child welfare agencies, or mainline service organizations with a "substance abuse prevention" or "family" label. Examples include the following:

1. Neighborhood leaders and informal networks
2. Community businesses
3. Neighborhood drop-in programs
4. Community centers
5. Religious organizations, such as churches, temples, and mosques
6. Centers for various cultural groups
7. Child care and Head Start programs
8. Literacy programs

It is also important to identify more formal resources that offer family-centered programs-including parent training, in-home support services, and family therapy. Such resources include, but are not limited to, the following:

1. School-based programs that offer parent training or education about substance abuse prevention
2. Child welfare agencies providing in-home support services to prevent separation of families or specialized foster parent training programs for children with special needs
3. Juvenile court programs that offer parent training or family therapy
4. Universities, community colleges, and hospitals or health clinics that provide special therapeutic services, parent training programs, or special demonstration or research programs

Family therapy interventions should be linked with the social and support services available in the target community. It is not enough to merely identify existing community resources. Practitioners need to establish ways their program can collaborate, coordinate, and perhaps share case management with these other support

services. Formal and informal agreements, including memorandums of understanding, case management meetings, and regular multidisciplinary interagency trainings, are helpful. A contract or some other mechanism is necessary to spell out roles and services, such as joint referral, intake, and assessment procedures. Based on these, practitioners need to develop detailed guidance for families on how to best use the other community resources.

CONCLUSION

This practitioner's guide is intended to be brief and simple. For much greater detail concerning the analysis of the three prevention approaches, recommendations for practice, guides for program development and delivery, and emerging areas of research and practice, see the reference guide.

Practitioners face many challenges in their efforts to intervene with families to prevent substance abuse in their children. Despite the complexity of the challenges, a growing body of research and practice literature has documented successful strategies for family-centered interventions. *For the first time, information on these strategies and interventions has been brought together in a systematic analysis of their effectiveness.* The resulting guidelines are designed to be clear, realistic, and easy to use. It is hoped that they will help develop markedly more effective family-centered approaches to prevent substance abuse among children and adolescents.

AN AFTERWORD: EMERGING AREAS OF RESEARCH AND PRACTICE

Two issues of interest to practitioners have not been included in this guide's review of research and practice. These issues are the constructs of resilience and family support. Many may wonder why two prevention approaches and strategies that are widely discussed and often funded are not included in the reference guide or this practitioner's guide. The reason is that these approaches did not meet the rigorous criteria used to select approaches: an ample body of research and/or practice evidence sufficient to permit a thorough analysis. For both of these strategies, the research evidence is in the early stages.

The Construct of Resilience

For the purposes of this guide, resilience is defined as either of the following capacities of children (Herrenkohl, Herrenkohl, and Egolf 1994; Luthar 1991; Luthar and Cushing, in press; Turner, Norman, and Zunz 1993):

- The capacity to recover from traumatic life events and restore or improve family functioning. Traumatic life events include the death of a parent, divorce, sexual abuse, and homelessness.

- The capacity to withstand chronic stress and yet sustain competent functioning. Examples of chronic stress are extreme poverty, alcoholic parents, chronic illness, and ongoing domestic or neighborhood violence.

Most resilience researchers agree that resilience involves an interaction among characteristics of the child, the family, and community environments and exposure to adverse circumstances, especially at an early age. However, intervention-based studies are distinctly lacking, so little is known about how these elements interact. Vital questions remain:

- To what extent does resilience rely on and build on biological traits as opposed to learned patterns of behavior?
- Can everyone learn to be resilient, or must certain conditions be present?

The Construct of Family Support

The driving force behind the family support construct is the conviction that it is the responsibility of family-helping programs and resources to go beyond preventing problems to supporting the optimum development of the capacities that are inherent in all families. This approach is often called "empowerment." Vital assumptions are that the primary responsibility for the development and well-being of children lies within the family, that family services should be rooted in community support systems, and that the role of help-giving agencies is to become partners with families in problem solving (Family Resource Coalition 1996).

Researchers and practitioners who evaluate family support interventions believe that the traditional evaluation approaches are insufficient. They contend that family support research should involve participants in research design and implementation and employ methods that make them stakeholders in evaluation goals and results.

Recent and ongoing research efforts include the following:

- Identifying the importance of using informal resources to help families
- Determining how a family's style of functioning affects its capacity to cope and promote positive growth
- Describing the effects that various modes of helping might have on an individual's ability to become more independent

A general problem in the development of a body of knowledge about family support has been the lack of data sources and information about family and community strengths and assets. Most of the data about families describe either neutral or deficit information, problems, and needs. Until more data are collected and analyzed, it will be difficult to identify which strengths and assets are most useful for helping families achieve optimum results.

Final Thoughts About Resilience and Family Support

Interventions based on resilience and family support offer program options that might be more effective and less expensive than traditional treatment or deficit-focused strategies. As practitioners experiment with interventions that make intuitive sense and address the problems they see each day, the challenge for research is to keep pace with practice by:

- Further defining these constructs
- Developing accurate measures
- Incorporating evaluation processes that include participants
- Assembling the findings into an integrated body of evidence

This points to many opportunities for researchers and practitioners to work together to determine what works and subsequently increase the impact of interventions using these constructs.

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Family In-Home Support

Research Evidence

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Practice Evidence

The *In-Home Care Demonstration Projects* of the Office of Child Abuse Prevention, Department of Social Services, State of California. Sacramento, California.

The *Intensive Family Preservation Services* of the State of Connecticut. Hartford, Connecticut.

Family Therapy

Research Evidence

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Appendix A: Criteria for Establishing Levels of Evidence of Effectiveness

The following descriptions are intentionally brief. For a more rigorous definition of the criteria, refer to the reference guide.

STRONG LEVEL OF EVIDENCE

Consistent results of strong or medium effect from:

- At least **three** studies with experimental or quasi-experimental designs

  and
- The use of at least **two** different methodologies

OR

- **Two** studies with experimental or quasi-experimental designs

  and
- At least **three** case studies

MEDIUM LEVEL OF EVIDENCE

Consistent positive results from:

- At least **two** studies with experimental or quasi-experimental designs

  and
- The use of at least **two** different methodologies

OR

- **One** study with experimental or quasi-experimental design

  and
- At least **three** case studies

SUGGESTIVE BUT INSUFFICIENT EVIDENCE

Research or practice evidence that:

- Is based on a plausible rationale or on previous research *and*
- Is being demonstrated in well-designed studies or programs currently in process
- Minimally demonstrates that the intervention being tested is linked to a positive effect

SUBSTANTIAL EVIDENCE OF INEFFECTIVENESS

Research and practice evidence demonstrating that a prevention approach is not effective. The criterion for inclusion in this category is a statistically significant negative effect in a majority of competently done studies, including at least **two** quantitative studies with sample sizes sufficient to test for the significance of the effect.

Appendix B: Abbreviations and Glossary of Terms Used in Family-Centered Approaches to Substance Abuse Prevention

ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
ADHD	Attention-Deficit Hyperactivity Disorder
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AIDS	Acquired Immunodeficiency Syndrome
AODs	Alcohol and Other Drugs
ATP	Adolescent Transitions Program
BET	Bicultural Effectiveness Training
CAPS	Communication and Parenting Skills
CDC	Centers for Disease Control and Prevention
COSSMHO	National Coalition for Hispanic Health and Human Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DHHS	U.S. Department of Health and Human Services
FAST	Families and Schools Together
FET	Family Effectiveness Training
FFT	Functional Family Therapy
FRP	Federal Resource Panel

GDVM	Group Discussion-oriented Basic Parent Skills Training Program
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IOM	Institute of Medicine
IVM	Individually Self-administered Videotaped Modeling (Treatment)
IVMC	IVM Treatment plus Therapist Consultation
LSD	Lysergic Acid Diethylamide
MDMA	3-4-Methylenedioxymethamphetamine
MST	Multisystemic Therapy
NCHS	National Center for Health Statistics
NHIS	National Health Interview Survey
NHSDA	National Household Survey on Drug Abuse
NIAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NPHS	National Pregnancy and Health Survey
NPN	National Prevention Network
ONDCP	Office of National Drug Control Policy
OSAP	Office for Substance Abuse Prevention (now CSAP)
PCP	Phencyclidine
PDFY	Preparing for the Drug-Free Years (Program)
PEPS	Prevention Enhancement Protocols System
PHS	Public Health Service
PSST	Problem-Solving Skills Training
SAMHSA	Substance Abuse and Mental Health Services Administration
SFT	Structural Family Therapy
SSA	Single State Agency (State Substance Abuse agency)
STD	Sexually Transmitted Disease
TIP	Treatment Improvement Protocol
TOT	Training of Trainers
YRBSS	Youth Risk Behavior Surveillance System

GLOSSARY

Adjustment Disorder—a behavior-related disorder in which a person exhibits clinically significant emotional or behavioral symptoms in response to a psychosocial stressor. Includes distress in excess of expectations or significant impairment in social or academic functioning. *See* attention-deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder.

Antisocial and Other Problem Behaviors—can describe behavior-related problems (e.g., poor conduct and impulsiveness), behavior-related disorders (e.g., attention-deficit hyperactivity disorder), or both.

Assignment—the process by which researchers place study subjects in an intervention, control, or comparison group. Experimental design studies randomly assign study subjects to both intervention and control conditions. Quasi-experimental studies nonrandomly assign study subjects to intervention and comparison conditions. Random assignment increases the likelihood that the intervention and control groups are equal or comparable and have similar characteristics.

Attention-Deficit Hyperactivity Disorder—a behavior-related disorder in which there is a persistent pattern of inattention and/or hyperactivity and impulsivity. *See* adjustment disorder, conduct disorder, and oppositional defiant disorder.

Attrition—an unplanned reduction in the size of the study sample caused by participants dropping out of the evaluation, such as due to relocation.

Behavioral Factor—a certain pattern of conduct that may be associated with substance abuse-related attitudes or behavior. Most prominent in substance abuse prevention efforts are behavioral factors that lead to the perception of substance use or related conditions as functional or appropriate. *See* environmental factor, personal factor, and sociodemographic factor.

Behavior-Related Disorder—a specific behavioral problem that occurs in persistent patterns and characteristic clusters and causes clinically significant impairment. *See* behavior-related problem.

Behavior-Related Problem—a behavioral problem that is isolated or intermittent and is not part of a persistent behavior pattern and that varies in severity and seriousness of its consequences. *See* behavior-related disorder.

Bias—the extent to which a measurement, sampling, or analytic method systematically underestimates or overestimates the true value of an attribute. In general, biases are sources of systematic errors that arise from faulty designs, poor data collection procedures, or inadequate analyses. These errors diminish the likelihood that observed outcomes are attributable to the intervention.

Case Study—a method for learning about a complex instance, based on a comprehensive understanding of that instance, obtained by extensive description and analysis of the instance, taken as a whole and in its context.

Conduct Disorder—a behavior-related disorder in which there is a repetitive and persistent pattern of violating the basic rights of others or major age-appropriate societal norms or rules. It can include aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. *See* adjustment disorder, attention-deficit hyperactivity disorder, and oppositional defiant disorder.

Community—a group of individuals who share cultural and social experiences within a common geographic or political jurisdiction.

Community-Based Approach—a prevention approach that focuses on the problems or needs of an entire community, including large cities, small towns, schools, worksites, and public places. *See* individual-centered approach.

Community Readiness—the degree of support for or resistance to identifying substance use and abuse as significant social problems in the community. Stages of community readiness for prevention provide an appropriate framework for understanding prevention readiness at the community or State level. *See* community tolerance, confirmation/expansion, denial, initiation, institutionalization, preparation, preplanning, professionalization, and vague awareness.

Community Tolerance—a condition in which community norms actively encourage problematic behavior, which is viewed as socially acceptable. *See* community readiness.

Comparison Group—in quasi-experimental evaluation design, a group of evaluation participants that is not exposed to the intervention. This term usually implies that participants are *not* randomly assigned, but have characteristics similar to the intervention group. *See* control group.

Conceptual Framework—in this guideline, the philosophical basis for a prevention approach. Specifically, the assumed reasons or hypotheses that explain why the interventions in a specific prevention approach should work.

Confirmation/Expansion—the stage in which existing prevention programs are viewed as effective and authorities support expansion or improvement of the efforts. Data are routinely collected at this stage, and there is a clear understanding of the local problem and the risk factors for the problem. New programs are being planned to reach other community members at this stage. *See* community readiness.

Construct—an attribute, usually unobservable, such as educational attainment or socioeconomic status, that is represented by an observable measure.

Contextualism—a theory that all behavior must be understood within the context of its occurrence. Context is broadly defined to include not only transactions between an individual and his or her immediate environment, but also between and among the individual and the domains of family, school, peers, community, and the larger societal or global environment. *See* developmental pathways model, social development model, and social ecology model.

Control Group—in experimental evaluation design, a group of participants that is essentially similar to the intervention group but is not exposed to the intervention. Participants are designated to be part of either a control or intervention group through random assignment. *See* comparison group.

Conventional Primary Prevention—substance abuse prevention approaches that focus on deterring initial use. *See* conventional secondary prevention.

Conventional Secondary Prevention—psychology-based substance abuse prevention approaches that encourage people to stop. *See* conventional primary prevention.

Correlational Analysis—a form of relational analysis that assesses the strength and direction of association between variables.

Cross-Sectional Design—a research design that involves the collection of data on a sample of the population at a single point in time. When exposure and health status data are collected, measures of associations between them are easily computed. However, because health status and exposure are measured simultaneously, inferences cannot be made that the exposure causes the health status.

Data—information collected according to a methodology using specific research methods and instruments.

Data Analysis—the process of examining systematically collected information.

Denial—the stage in which the behavior is not usually approved of according to community norms. At this stage, people are aware that the behavior is a problem but believe that nothing needs to or can be done about the behavior at a local level. *See* community readiness.

Design—often referred to as research or study design. An outline or plan of the procedures to be followed in scientific experimentation in order to reach valid conclusions. *See* experimental design, nonexperimental design, quasi-experimental design, and pre-post test.

Designer Drug—a substance that is a synthetic analogue of a controlled substance, manufactured illegally for the specific purpose of abuse. Created by making minor changes in the molecular structure of substances such as amphetamines.

Developmental Pathways Model—a model that argues that the presence of certain risk factors in a child's life, whether individual, familial, or social in nature, can predispose him or her to engage in negative behaviors, which in turn may lead to additional adverse events and circumstances and further counterproductive and disadvantageous interactions. *See* contextualism, social development model, and social ecology model.

Dual Diagnosis—a term used to describe the phenomenon of coexisting psychiatric and substance abuse disorders.

Effect—a result, impact, or outcome. In evaluation research, attributing an effect to a program or intervention requires establishing, through comparison, a logical relationship between conditions with and without the program or intervention.

Effectiveness—the degree to which a prevention approach or intervention achieves specified objectives or outcomes. *See* effectiveness evaluation and efficacy evaluation.

Effectiveness Evaluation—an evaluation that assesses an intervention under practice conditions—typically, the implementation of an intervention in the field. *See* effectiveness and efficacy evaluation.

Efficacy Evaluation—an evaluation used when an intervention is assessed under optimal program conditions—usually a well-funded project conducted by researchers. *See* effectiveness and effectiveness evaluation.

Environmental Factor—a factor that is external or is perceived to be external to an individual but that may nonetheless affect his or her behavior. A number of these factors are related to the individual's family of origin, while others have to do with social norms and expectations. *See* behavioral factors, personal factor, and sociodemographic factor.

Experimental Design—a research design that includes random selection of study subjects, an intervention and a control group, random assignment to the groups, and measurements of both groups. Measurements are typically conducted before and always after the intervention. The results obtained from these studies typically yield the most interpretable, definitive, and defensible evidence of effectiveness. *See* design, nonexperimental design, pre-post test, and quasi-experimental design.

External Validity—the extent to which outcomes and findings apply (or can be generalized) to persons, objects, settings, or times other than those that were the subject of the study. *See* validity.

Fami'y—parents (or persons serving as parents) and children who are related either through biology or through assignment of guardianship, whether formally (by law)

or informally, and who are actively involved together in family life—sharing a social network, material and emotional resources, and sources of support.

Family In-Home Support—a prevention approach that addresses risk and protective factors by focusing on preserving families through intervention in their home environments. *See* family therapy and parent and family skills training.

Family Support—a proactive construct that views parenting as a developmentally learned task for all families and affirms that strategies for delivering family services should be rooted in a community support system. *See* resilience.

Family Therapy—a prevention approach that provides professionally led counseling services to a family for the purpose of decreasing maladaptive family functioning and negative behaviors and increasing skills for healthy family interaction. *See* family in-home support and parent and family skills training.

Focus Group—a qualitative research method consisting of a structured discussion among a small group of people with shared characteristics. Focus groups are designed to identify perceptions and opinions about a specific issue. They can be used to elicit feedback from target group subjects about prevention strategies.

Formative Evaluation—a process that is concerned with helping the developer of programs or products through the use of empirical research methodology. Also called feedback evaluation.

Fugitive Literature—articles or materials of a scientific or academic nature that are typically unpublished, informally published, or not readily available to the scientific community, such as internal reports and unpublished manuscripts. In this guideline, some practice cases are considered fugitive literature.

Gateway Hypothesis—a hypothesis which states that the use of alcohol and tobacco at an early age is associated with progression to illicit drug use and greater involvement with drugs at older ages.

Heavy Drinker—a person who consumes 2 or more alcoholic beverages per day or 14 or more alcoholic beverages per week.

Incidence—the number of new cases of a disease or occurrences of an event in a particular period of time, usually expressed as a rate with the number of cases as the numerator and the population at risk as the denominator. Incidence rates are often presented in standard terms, such as the number of new cases per 100,000 population.

Indicated Preventive Measure—a preventive measure that is directed to specific individuals with known, identified risk factors. *See* preventive measure, selective preventive measure, and universal preventive measure.

Individual-Centered Approach—a prevention approach that focuses on the problems and needs of the individual. *See* community-based approach.

Initiation—the stage in which a prevention program is under way but is still "on trial." Community members often have great enthusiasm for the effort at this stage because obstacles have not yet been encountered. *See* community readiness.

Institutionalization—occurs when several programs are supported by local or State governments with established (but not permanent) funding. Although the program is accepted as a routine and valuable practice at this stage, there is little perceived need for change or expansion of the effort. *See* community readiness.

Instrument—a device that assists evaluators in collecting data in an organized fashion, such as a standardized survey or interview protocol. *See* methodology.

Intermediate Outcome—an intervention outcome, such as changes in knowledge, attitudes, or beliefs, that occurs prior to and is assumed to be necessary for changes in an ultimate or long-term outcome, such as prevention of or decreases in substance use and substance-related problems.

Internal Validity—the ability to make inferences about whether the relationship between variables is causal in nature and, if it is, the direction of causality.

Intervention—a manipulation applied to a group in order to change behavior. In substance abuse prevention, interventions at the individual or environmental level may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

Intended Measurable Outcome—in this guideline, the overall expected consequences and results of the interventions within each prevention approach.

Lesson Learned—in this guideline, a conclusion that can be reached about a specific prevention approach that is based on the research and practice evidence reviewed to evaluate that prevention approach.

Longitudinal Data—observations collected over a period of time; the sample may or may not be the same each time (sometimes called time series data).

Maturation Effect—a change in outcome that is attributable to participants' growing wiser, stronger, more experienced, and the like, solely through the passage of time.

Mean—the arithmetic average of a set of numeric values.

Methodology—a procedure for collecting data. *See* instrument.

Multicomponent Program—a prevention approach that simultaneously uses multiple interventions that target one or more substance abuse problems. Programs that involve coordinated multiple interventions are likely to be more effective in achieving the desired goals than single-component programs and programs that involve multiple but uncoordinated interventions. *See* single-component program.

Multivariate—an experimental design or correlational analysis consisting of many dependent variables. *See* variable.

Nonexperimental Design—a type of research design that does not include random assignment or a control group. With such research designs, several factors prevent the attribution of an observed effect to the intervention. *See* design, experimental design, pre-post test, and quasi-experimental design.

Oppositional Defiant Disorder—a behavior-related disorder showing a recurrent pattern of negative, defiant, disobedient, and hostile behavior toward authority figures. Includes some features of conduct disorder, but does not include the persistent pattern of violating the rights of others or major societal norms or rules. *See* adjustment disorder, attention-deficit hyperactivity disorder, and conduct disorder.

Outcome Evaluation or Summative Evaluation—analysis that focuses research questions on assessing the effects of interventions on intended outcomes. *See* process evaluation and program evaluation.

Parent and Family Skills Training—a prevention approach in which parents are trained to develop new parenting skills and children are trained to develop prosocial skills. *See* family in-home support and family therapy.

Personal Factor—a cognitive process, value, personality construct, and sense of psychological well-being inherent to an individual and through which societal and environmental influences are filtered. *See* behavioral factor, environmental factor, and sociodemographic factor.

Practice Evidence—information obtained from prevention practice cases, which are generally compiled in the form of case studies and often include information about evaluating program implementation and procedures. *See* research evidence.

Pre-Post Test—in research design, the collection of measurements before and after an intervention to assess its effects. *See* design, experimental design, nonexperimental design, and quasi-experimental design.

Preparation—the stage in which plans are being made to prevent the problem, leadership is active, funding is being solicited, and program pilot testing may be occurring. *See* community readiness.

Preplanning—the stage in which there is a clear recognition that a problem with the behavior exists locally and that something should be done about it. At this stage, general information on the problem is available and local leaders needed to advance change are identifiable, but no real planning has occurred. *See* community readiness.

Prevalence—the number of all new and old cases of a disease or occurrences of an event during a particular period of time, usually expressed as a rate with the number of cases or events as the numerator and the population at risk as the denominator. Prevalence rates are often presented in standard terms, such as the number of cases per 100,000 population.

Prevention Approach—a group of prevention activities that broadly share common methods, strategies, assumptions (theories or hypotheses), and outcomes.

Preventive Measure—a cluster of interventions that share similarities with regard to the population groups among which they are optimally used. *See* indicated preventive measure, selective preventive measure, and universal preventive measure.

Primary Prevention—efforts that seek to decrease the number of new cases of a disorder. *See* secondary prevention and tertiary prevention.

Probability Sampling—a method for drawing a sample from a population such that all possible samples have a known and specified probability of being drawn.

Process Evaluation—an assessment designed to document and explain the dynamics of a new or continuing prevention program. Broadly, a process evaluation describes what happened as a program was started, implemented, and completed. A process evaluation is by definition descriptive and ongoing. It may be used to the degree to which prevention program procedures were conducted according to a written program plan. *See* outcome evaluation or summative evaluation and program evaluation.

Professionalization—the stage in which detailed information has been gathered about the prevalence, risk factors, and etiology of the local problem. At this point, various programs designed to reach general and specific target audiences are under way. Highly trained staff run the program, and community support and involvement are strong. Also at this stage, effective evaluation is conducted to assess and modify programs. *See* community readiness.

Program Evaluation—the application of scientific research methods to assess program concepts, implementation, and effectiveness. *See* outcome evaluation or summative evaluation and process evaluation.

Promotion Model—a method of enhancing and making the most of people's positive functioning through the development and improvement of competence and capabilities that strengthen people's functioning and their capacity to adapt.

Protective Factor—an influence that inhibits, reduces, or buffers the probability of drug use, abuse, or a transition to a higher level of involvement with drugs. *See* risk factor.

Qualitative Data—contextual information in evaluation studies that usually describes participants and interventions. Often presented as text, the strength of qualitative data is their ability to illuminate evaluation findings derived from quantitative methods. *See* quantitative data.

Quantitative Data—in evaluation studies, measures that capture changes in targeted outcomes (e.g., substance use) and intervening variables (e.g., attitudes toward use). The strength of quantitative data is their use in testing hypotheses and determining the strength and direction of effects. *See* qualitative data.

Quasi-Experimental Design—a research design that includes intervention and comparison groups and measurements of both groups, but in which assignment to the intervention and comparison conditions is not done on a random basis. With such research designs, attribution of an observed effect to the intervention is less certain than with experimental designs. *See* design, experimental design, nonexperimental design, and pre-post test.

Questionnaire—research instrument that consists of written questions, each with a limited set of possible responses.

Random Assignment—the process through which members of a pool of eligible study participants are assigned to either the intervention group or a control group on a random basis, such as through the use of a table of random numbers.

Reliability—the extent to which a measurement process produces similar results on repeated observations of the same condition or event.

Reliable Measure—a measure that will produce the same result (score) when applied two or more times. *See* valid measure.

Representative Sample—a segment of a larger body or population that mirrors in composition the characteristics of the larger body or population.

Research—the systematic effort to discover or confirm facts by scientific methods of observation and experimentation.

Research Evidence—information obtained from research studies conducted to evaluate the effectiveness of an intervention and published in peer-reviewed journals. *See* practice evidence.

Resilience—either the capacity to recover from traumatically adverse life events (e.g., the death of a parent, divorce, sexual abuse, homelessness, or a catastrophic event) and other types of adversity so as to achieve eventual restoration or improvement of competent functioning; or the capability to withstand chronic stress (e.g., extreme poverty, alcoholic parents, chronic illness, or ongoing domestic or neighborhood violence) and to sustain competent functioning despite ongoing stressful and adverse life conditions. *See* family support.

Risk Factor—a condition that increases the likelihood of substance abuse. *See* protective factor.

Secondary Prevention—efforts that seek to lower the rate of established cases. *See* primary prevention and tertiary prevention.

Selective Preventive Measure—a preventive measure that is directed to subgroups of the populations that have a higher than average risk for developing a problem or disorder. *See* indicated preventive measure, preventive measure, and universal preventive measure.

Simple Random Sample—in experimental research designs, a sample derived from indiscriminate selection from a pool of eligible participants, such that each member of the population has an equal chance of being selected for the sample. *See* stratified random sample.

Single-Component Program—a prevention approach using a single intervention or strategy to target one or more problems. *See* multicomponent program.

Social Development Model—a model that seeks to explain behaviors that are themselves risk factors for substance abuse by specifying the socialization processes (the interaction of developmental mechanisms carried out through relationships with family, school, and peers) that predict such behaviors. *See* contextualism, developmental pathways model, and social ecology model.

Social Ecology Model—a model that posits that an adolescent's interactions with social, school, and family environments ultimately influence substance abuse and other antisocial behaviors. It also emphasizes the importance of increasing opportunities within the social environment for youth to develop social competencies and self-efficacy. *See* contextualism, developmental pathways model, and social development model.

Sociodemographic Factor—a social trend, influence, or population characteristic that affects substance abuse-related risks, attitudes or behaviors. Such factors have an indirect but powerful influence because of the limitations of the political, social, economic, and educational systems of society. *See* behavioral factor, environmental factor, and personal factor.

Statistical Significance—the strength of a particular relationship between variables. A relationship is said to be statistically significant when it occurs so frequently in the data that the relationship's existence is probably not attributable to chance.

Stratified Random Sample—in experimental research designs, a sample group derived from indiscriminate selection from different subsegments of a pool of eligible participants (e.g., men and women). *See* simple random sample.

Substance Abuse—the consumption of psychoactive drugs in such a way that it significantly impairs an individual's functioning in terms of physical, psychological, or emotional health; interpersonal interactions; or functioning in work, school, or social settings. The use of psychoactive drugs by minors is considered substance abuse.

Tertiary Prevention—efforts that seek to decrease the amount of incapacity associated with an existing condition. *See* primary prevention and secondary prevention.

Threats to Internal Validity—the factors other than the intervention that evaluators must consider when a program evaluation is conducted, regardless of the rigor of the evaluation design, that might account for or influence the outcome. They diminish the likelihood that an observed outcome is attributable to the intervention.

Time-Series Design—a research design that involves an intervention group evaluated at least once before the intervention and retested more than once after the intervention. A time-series analysis involves the examination of fluctuations in the rates of a condition over a long period in relation to the rise and fall of a possible causative agent.

Universal Preventive Measure—a preventive measure that is directed to a general population or a general subsection of the population that has not been identified on the basis of risk factors, but for which the prevention activity could reduce the likelihood of problems developing. *See* indicated preventive measure, preventive measure, and selective preventive measure.

Vague Awareness—the stage in which there is a general feeling that a behavior is a local problem that requires attention. However, knowledge about the extent of the problem is sparse, there is little motivation to take action to prevent it, and there is a lack of leadership to address it. *See* community readiness.

Valid Measure—an accurate assessment of what the evaluator wants to measure. *See* reliable measure.

Validity—the ability of an instrument to measure what it purports to measure. *See* external validity.

Variable—a factor or characteristic of the intervention, participant, and/or the context that may influence or be related to the possibility of achieving intermediate and long-term outcomes. *See* multivariate.

NOTE: This glossary is based partially on work performed by Westover Consultants, Silver Spring, Maryland, and the Pacific Institute for Research and Evaluation, Bethesda, Maryland, under other contracts with the Center for Substance Abuse Prevention.

Appendix C: Resource Guide

This Resource Guide provides suggestions for family-centered resources. The first section lists names and addresses of researchers and practitioners whose work was considered as evidence in evaluating the various intervention programs. Names and addresses reflect information that was current at the time these individuals were last involved with PEPS. Because detailed descriptions of their program planning and content are beyond the scope of this guideline (and often are not fully described in their published works), CSAP thought that those interested in implementing specific strategies might want to obtain more detailed information directly from these researchers and practitioners. The second section of this appendix lists the various Federal Government agencies and nongovernment organizations that provide information, resources, and guidance regarding family-related interventions and programs. Some of these organizations have information clearinghouses. It also lists examples of foundations that provide support for family-centered interventions or research. Some of the foundations also provide educational materials for practitioners or the lay public.

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57 West South Temple, Suite 420
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P.O. Box 47054
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Office of Child Abuse Prevention
744 P Street, Mail Slot 19-82
Sacramento, CA 95814

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361 Bird Street
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Seattle, WA 98104

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1228 East Breckenridge Street
Louisville, KY 40204

Linda Wheeler
Families and Schools Together Program
Family Service America
11700 West Lake Park Drive
Milwaukee, WI 53224-3099

AGENCIES, ORGANIZATIONS, AND FOUNDATIONS

Government Agencies

Administration for Children and Families

- **Administration on Children, Youth, and Families**
  330 C Street, S.W., Room 2026
  Washington, DC 20201
  (202) 205-8347
  Internet: http://www.acf.dhhs.gov

- **Children's Bureau**
  330 C Street, S.W., Room 2070
  Washington, DC 20201
  (202) 205-8618

- **Child Care Bureau**
  200 Independence Avenue, S.W.
  Room 320F
  Washington, DC 20201
  (202) 401-6947

- **Child Welfare Bureau**
  330 C Street, S.W., Room 2068
  Washington, DC 20201
  (202) 205-8618

- **Family and Youth Services Bureau**
  330 C Street, S.W., Room 2046
  Washington, DC 20201
  (202) 205-8102

- **Head Start Bureau**
  330 C Street, S.W., Room 2058
  Washington, DC 20201
  (202) 205-8573

- **National Child Care Information Center**
  301 Maple Avenue West, Suite 602
  Vienna, VA 22180
  (800) 616-2242
  http://www.ericps.ed.uiuc.edu/nccic

- **National Clearinghouse on Child Abuse and Neglect Information**
  P.O. Box 1182
  Washington, DC 20013-1182
  (800) FYI-3366
  (703) 385-7565
  http://www.calib.com/nccanch

- **National Clearinghouse on Families and Youth**
  P.O. Box 13505
  Silver Spring, MD 20911-3505
  (301) 608-8098

- **Office on Child Abuse and Neglect**
  330 C Street, S.W., Room 2026
  Washington, DC 20201
  (202) 205-8586

Center for Substance Abuse Prevention

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
(800) 729-6686
http://www.samhsa.gov/csap

- **Department of Education**
  600 Independence Avenue, S.W.
  Portals Building
  Washington, DC 20202-6123
  (800) 872-5327
  (202) 401-2000
  http://www.ed.gov

- **Office of Elementary and Secondary Education**
  Safe and Drug Free Schools
  600 Independence Avenue, S.W.
  Portals Building
  Washington, DC 20202-6123
  (202) 260-3954

- **Even Start Family Literacy Program**
  600 Independence Avenue, S.W.
  Portals Building
  Washington, DC 20202
  (202) 260-2777

- **Department of Health and Human Services**
  Office of the Assistant Secretary for Planning and Evaluation
  200 Independence Avenue, S.W.
  Hubert H. Humphrey Building, Room 415F
  Washington, DC 20201
  (202) 690-7858
  http://www.hhs.gov

- **Division of Children and Youth Policy**
  200 Independence Avenue, S.W.
  Hubert H. Humphrey Building, Room 450G
  Washington, DC 20201
  (202) 690-6461

- **Division of Public Health Policy**
  200 Independence Avenue, S.W.
  Hubert H. Humphrey Building, Room 442E
  Washington, DC 20201
  (202) 690-6870

- **Department of Labor**
  200 Constitution Avenue, N.W., Room S-1032
  Washington, DC 20210-0002
  (202) 219-8211
  http://www.dol.gov

- **Women's Bureau Clearinghouse**
  200 Constitution Avenue, N.W., Room S3306
  Washington, DC 20210-0002
  (800) 827-5335

- **Work and Family Clearinghouse**
  200 Constitution Avenue, N.W., Room 3317
  Washington, DC 20210-0002
  (202) 219-4486

- **Housing and Urban Development**
  451 7th Street, S.W.
  Washington, DC 20410
  (202) 708-1420
  http://www.hud.gov

- **Community Connections Information Center**
  Office of Community Planning and Development
  P.O. Box 7189
  Gaithersburg, MD 20898-7189
  (800) 998-9999

- **University Partnership Clearinghouse**
  HUD USER
  P.O. Box 6091
  Rockville, MD 20849
  (800) 245-2691

- **Indian Health Service**
  Division of Clinical/Preventive Services
  5600 Fishers Lane, Room 6A-55
  Rockville, MD 20857
  (301) 443-4644
  http://www.ihs.gov

- **Maternal and Child Health Bureau**
  Health Resources and Services Administration
  5600 Fishers Lane, Room 18-20
  Rockville, MD 20857
  (301) 443-0205
  http://www.hrsa.dhhs.gov

- **Division of Healthy Start**
  5600 Fishers Lane, Room 11A-13
  Rockville, MD 20857
  (301) 443-0509

- **Division of Services for Children With Special Health Needs**
  5600 Fishers Lane, Room 18A-27
  Rockville, MD 20857
  (301) 443-2350

- **Division of Maternal, Infant, Child and Adolescent Health**
  5600 Fishers Lane, Room 18A-30
  Rockville, MD 20857
  (301) 443-2250

- **Juvenile Justice Clearinghouse**
  P.O. Box 6000
  Rockville, MD 20850
  (800) 638-8736
  http://ncjrs.aspensys.com

Nongovernmental Organizations

American Association for Marriage and Family Therapy
Research and Education Foundation
1133 15th Street, N.W., Suite 300
Washington, DC 20005
(202) 452-0109
http://www.aamft.org

American Public Welfare Association
810 First Street, N.E., Suite 500
Washington, DC 20002-4267
(202) 682-0100

Center for Family Life in Sunset Park
345 43rd Street
Brooklyn, NY 11232
(718) 788-3500

Children's Defense Fund
25 E Street, N.W.
Washington, DC 20001
(202) 628-8330
(202) 628-8787
http://www.childrensdefense.org

The Children's Foundation
725 15th Street, N.W., Suite 505
Washington, DC 20005
(202) 347-3300

Child Welfare League of America
440 First Street, N.W., Suite 310
Washington, DC 20001-2085
(202) 638-2952
http://www.cwla.org

Family Resource Coalition
200 South Michigan Avenue, 16th Floor
Chicago, IL 60604
(312) 341-0900

The C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
1205 Oneida Street
Denver, CO 80220
(303) 321-3963
http://www.kempecenter. org

National Association of Child Care Resource and Referral Agencies
1319 F Street, N.W., Suite 810
Washington, DC 20004-1106
(202) 393-5501

National Black Child Development Institute
1023 Fifteenth Street, N.W., Suite 600
Washington, DC 20005
(202) 387-1281
http://www.nbcdi.org

National Center for Children in Poverty
Columbia University School of Public Health
Columbia University
154 Haven Avenue
New York, NY 10032
(212) 927-8793
(212) 304-7100
http://cpmcnet.columbia.edu/dept/nccp

National Center for the Early Childhood Work Force
733 15th Street, N.W., Suite 800
Washington, DC 20005
(202) 737-7700

National Child Care Information Center
301 Maple Avenue West, Suite 602
Vienna, VA 22180
(800) 616-2242
Fax 1 (800) 716-2242
http://ericps.ed.uiuc.edu/nccic

National Head Start Association
1651 Prince Street
Alexandria, VA 22314
(703) 739-0875
http://www.nhsa.org

National Indian Child Care Association
279 East 137th Street
Glenpool, OK 74033
(918) 756-2112

National Indian Child Welfare Association
3611 SW Hood St., Suite 201
Portland, OR 97201
(503) 222-4044

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013-1492
(800) 695-0285
http://www.nichcy.org

National Information Clearinghouse for Infants With Disabilities and Life-Threatening Conditions
University of South Carolina
Benson Building, First Floor
Columbia, SC 29208
(800) 922-9234
(803) 777-4435

National Maternal and Child Health Clearinghouse
8201 Greensboro Drive, Suite 600
McLean, VA 22102-3843
(703) 821-8955

National Parent Information Network
ERIC Clearinghouse on Elementary and Early Childhood Education
University of Illinois at Urbana-Champaign
Children's Research Center
51 Gerty Drive
Champaign, IL 61820-7469
(217) 333-1386
http://www.uiuc.edu

National Resource Center on Child Abuse and Neglect
63 Inverness Drive East
Englewood, CO 80112-5117
(800) 227-5242

National Youth Center Network
254 College Street, Suite 501
New Haven, CT 06510
(203) 773-0770
http://www.nycn.org

Zero To Three: National Center for Infants, Toddlers, and Families
734 15th Street, N.W., Tenth Floor
Washington, DC 20005-2101
(202) 638-1144
(800) 899-4301 (publications)
http://www.zerotothree.org

Foundations

The following are illustrative of private foundations that provide grants for services and research regarding family-centered interventions. Grantmaker organizations such as The Foundation Center can provide information on the wide array of private foundations, corporate grantmakers, grantmaking public charities, and community foundations.

The Carnegie Corporation of New York
437 Madison Avenue
New York, NY 10022
(212) 371-3200
http://www.carnegie.org

The Annie E. Casey Foundation
701 St. Paul Street
Baltimore, MD 21202
(410) 546-6600
http://www.aecf.org

The Foundation Center
79 Fifth Avenue/16th Street
New York, NY 10003-3076
(212) 620-4230
http://fdncenter.org

The Ford Foundation
320 East 43rd Street
New York, NY 10017
(212) 573-5000
http://www.fordfound.org

The William Randolph Hearst Foundations
888 Seventh Avenue,
45th Floor
New York, NY 10106-0057
(212) 584-5404

The Robert Wood Johnson Foundation
Route 1 and College Road East
P.O. Box 2316
Princeton, NJ 08543-2316
(609) 452-8701
http://www.rwjf.org

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(415) 854-9400
http://www.kff.org

The W.K. Kellogg Foundation
One Michigan Avenue East
Battle Creek, MI 49017-4058
(616) 968-1611
http://www.wkkf.org

The John D. and Catherine T. MacArthur Foundation
140 S. Dearborn Street, Suite 1100
Chicago, IL 60603-5285
(312) 727-8000
http://www. macfdn.org

The David and Lucile Packard Foundation
300 Second Street, Suite 200
Los Altos, CA 94022
(415) 948-7658
http://www.packfound.org

The Pew Charitable Trusts
2005 Market Street, Suite 1700
Philadelphia, PA 19103
(215) 575-9050
http://www.pewtrusts.com

DHHS Publication No. (SMA) 3224-FY 98
Printed 1998

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